DISCHARGE PLANNING AT RURAL AND SMALL TOWN HOSPITALS: 
HOW IS IT ACCOMPLISHED?

by

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Within Canadian society inequities exist in health status and health care provision. Residents of rural, isolated areas tend to fare worse when compared with their urban counterparts. Much of the research about health care provision is written for and from urban centres. However, the research in this thesis is not urban-based and addresses an issue important to rural communities. The research explores how discharge planning is accomplished at rural and small town acute care hospitals within the Northern Interior Health Region of British Columbia.

A descriptive qualitative methodology was used to address the research question. Fifteen semi-structured interviews were conducted at five different small town locations within the Northern Interior Health Region of British Columbia. At each location interviews were conducted with three key informants about the discharge planning practices utilized at the local hospital. These key informants were a practicing physician, a nurse employed at the hospital, and a recently discharged patient. Analysis of the interview transcripts revealed twenty-four themes. Eleven of these themes suggest that the rural and small town environment exerts a positive influence on discharge planning processes, practices, and outcomes. Thirteen of the emergent themes suggest that the rural and small town context negatively influences discharge planning. A comparative analysis across key informant groups found similarities across the groups with physician and nurse responses being most similar. The themes derived from the patient interviews were more unique. Results suggest that improving outcomes for patients discharged from rural and small town hospitals will require augmentation and coordination of community based supports such as home care nursing, mental health services, and social services. Increased
accessibility to specialist resources and more direct involvement of patients in planning for their post-hospital care needs are also indicated.
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Health care service delivery in Canada is currently in a state of discord. Continuing surgical wait lists, extended emergency room waits and the apparent chronic unavailability of acute care beds have generated discontentment. These concerns combined with health labour shortages and governmental demands that health care spending be limited, suggest a system in a state of crisis. Can universal health care as Canadians have come to expect, continue to exist? Does it truly exist now or is it simply a romantic ideal? Within the overall Canadian context substantial variations exist between segments of society with regards to health status and health care service provision. It is increasingly documented that members of the First Nations (Acheson, 1995; Bolaria & Bolaria, 1994; Frideres, 1993; Locust, 1999; MacMillan, MacMillan, Offord & Dingle, 1996) residents of inner city locations (Clark, Chumbler & Nadzam, 1994) and citizens living in rural and remote areas of the country (British Columbia, 1995; Pampalon, R., 1991; Pong, R., Atkinson, A., Irvine, A., MacLeod, M., Minore, B., Pegoraro, A., Pitblado, R., Stones, M. & Tesson, G., 1999) are disadvantaged with regards to attaining adequate health and health care services. Considering that between 22% and 38% of the Canadian population can be classified as rural (Statistics Canada, 2001), this is an alarming statistic.

The qualitative research study described in this thesis explores one aspect of health care delivery to rural peoples. Specifically, the research question asks “how is discharge planning accomplished at rural and small town hospitals within the Northern Interior Health Region (NIHR) of British Columbia?” By way of introduction, this first chapter outlines the research

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1 Health regions in British Columbia were restructured on December 12, 2001, mid way through this research. On that date, the Northern Interior Health Region referred to in this thesis ceased to exist. A modified Northern Interior Health Service Delivery Area was created.
question, the rationale and purpose for the research and clarifies key terms used throughout the thesis. Chapter two provides a summary of the existing literature on discharge planning. A general overview is offered as well as an explication of what is known or assumed about discharge planning from rural and small town hospitals. Chapter three details the methodology employed in the research. Sampling methods, participant recruitment, data collection, and analytical methods are described. The results of the research are presented in chapter four. The themes generated by each of the three key informant groups utilized in this research are specified. Narrative excerpts from the participants are provided to help illustrate themes. A comparison of themes across the three groups is also completed. Chapter five offers a concluding section and suggestions for further research.

Rationale for the Research

The issues involved in rural health and rural health care delivery are currently of heightened interest in Canada. It is increasingly acknowledged that existing health care policies and practices developed in urban settings have limited relevance for rural environments. Research in this area is supported at both the federal and provincial levels. Rural health care delivery is also a topic of great personal interest to this writer. I have had the opportunity to be employed for the past seven years as a social worker at the regional referral hospital in the health region explored in this research. Discharge planning activities constitute a large component of my work, and thus I am intimately familiar with the processes utilized at that facility. Many of the patients I work with come from rural areas outside of the urban centre where the regional hospital is located. At times, along with my fellow employees, we engage in discharge planning with these rural patients while at other times these patients are within a new region referred to as the Northern Health Authority. The location of this study was the previous NIHR and it will be referred to as such.
transferred to small community hospitals nearer their homes with the expectation that discharge planning occur from there. Interaction with the small hospitals highlights that at the regional centre we have resources both within the hospital and within the community which are not available in the smaller centres. For example, many of the rural and small town hospitals we deal with have no allied health professionals such as rehabilitation therapists or social workers on staff. As these resources are essential to how the regional hospital engages in discharge planning activities, how is it accomplished without these resources? As such, although I work with patients/staff from small communities, my knowledge of discharge planning practices is distinctly urban based. However, the rural and small town context and culture are not unfamiliar to me. I had the opportunity of being raised as a child in an isolated rural location and continue to have family that reside in such settings. These linkages provide me with the insight that the norms, values and behaviours of rural and small town people are distinct from their large urban centre counterparts. This distinctiveness is perhaps subtle when regarding specific instances, but taken together, becomes quite substantial. My personal experience suggests that small communities can be, at least in part, characterized by independent people and personal relationships. Taking care of oneself, yet looking out for others, are small community norms. Prior to initiating this research, I suspected that these characteristics would impact on discharge planning from rural and small town hospitals but I was unsure as to how.

Purpose of the Research

It is the intent of this research project to help fill the research and knowledge gap which exists regarding the realities of rural and small town hospitals with regards to one aspect of their functioning; discharge planning. Discharge planning is an elusive term. For the purposes of this research, discharge planning describes the development and enactment of a plan
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designed to assist an acute care hospital inpatient make the satisfactory transition to post hospitalization. Other definitions exist and will be explored more fully in Chapter Two.

Discharge planning by its nature, has both individual patient/family implications and systemic ramifications. The approach to and value assigned discharge planning varies by perspective. For example, health care administrators emphasise the financial ramifications associated with discharge planning (Black, Peterson & Martens, 2000). High quality discharge planning is associated with reduced length of stay (LOS) and fewer readmissions which reduces the demand on expensive and scarce acute care resources. Social work focuses on the process of holistic transitional planning and advocates for patient/family involvement (Donnelly, 1992; Feather, 1993; Nacman, 1990). Nursing tends to view discharge planning in the context of assuring continuity of care for a patient as they move through the health care system (O'Hare, 1988). Inherent in these differing perspectives and approaches, is the acknowledgement that discharge planning is an important aspect of health care delivery.

Despite the relative abundance of literature describing and discussing discharge planning in general, minimal exploration of discharge planning at rural or small town hospitals has been conducted. Assumptions about discharge planning from such hospitals appear in the literature but rigorous exploration has not been engaged in. Most authors assume that it is a difficult task with many barriers (e.g. Bull & Kane, 1996; Clark, Chumbler, Nadzam, 1994; Egan & Kadushin, 1995; Screffler, 1996). Others however, suggest that the nature of the rural environment has a positive impact on discharge planning (e.g. Arundel & Glouberman, 2001).

The lack of formal attention to researching discharge planning at rural and small community hospitals is curious, particularly as such hospitals are often characterised as having elongated Length of Stay (LOS), questionable admissions and low occupancy rates (Black, Peterson, & Martens, 2000). Length of stay, who is occupying a hospital bed and why, are topics of focus
in discharge planning. The proliferation of rural hospital closures in Canada (Pong et al., 1999) and the United States (Screffler, 1996) over the past decade due to non-sustainability is a testament of the importance of these issues.

In this research, the issue of discharge planning is explored from essentially two points of view using the experience of three key participants in the process. First, from the health system’s point of view, the thoughts, observations, and perceptions of physicians and hospital nurses on how discharge planning occurs with acute care patients at their small community hospitals are recorded. Second, from the point of view of recently discharged patients, an exploration of how they participated in the process and how successful the outcome was conducted. The results of this research project suggest directions for health care authorities regarding where to focus resources and attention in order to optimize discharge experiences for the people of rural Canada.

**Key Terms**

There are several terms which are repeated throughout this investigation which require definition to eliminate ambiguity and to ensure clarity. These are as follows:

- **Discharge Planning** - Several definitions and descriptions of discharge planning exist in the literature. These will be explored in chapter two and will not be elaborated on here. In this research the term ‘discharge planning’ is used to describe the development and enactment of a plan designed to assist an acute care hospital inpatient make the satisfactory transition to post-hospitalization. High quality discharge planning is characterized by patient post-discharge needs being satisfactorily met (acceptable levels of risk and adequate quality of life) while lower quality discharge planning is characterised by unacceptably high or low levels of risk for the patient and/or inadequate quality of life post-discharge.
Rural and Small Town (RST) – Rural and small town is defined by Statistics Canada as referring to “the population living outside the commuting zones of Larger Urban Centres (LUCs) – specifically, outside Census Metropolitan Areas (CMAs) and Census Agglomerations (CAs). RST includes all municipalities with urban population of 1,000 to 9,999, and rural areas where less than 50 percent of the employed individuals commute to the urban core of a CMA/CA” (Statistics Canada, December 2001). Many definitions of ‘rural’ exist which take into consideration a variety of characteristics such as geographic isolation, economic base, demographics, or the existence of ‘rural culture’. Statistics Canada “strongly suggest that the appropriate definition should be determined by the question being addressed” (November 2001, p. 12). When considering community level issues such as health care service delivery, it is suggested that the rural and small town definition is useful. The rural and small town context, is of critical importance in this research. To reduce repetition throughout this thesis, at times the term “small community” is substituted for rural and small town but the definition remains consistent.

Acute Care Hospital - For the purposes of this research the word/term ‘hospital’ will used interchangeably with the term ‘acute care hospital’. An acute care hospital is defined as a medical facility which provides 24 hour per day nursing observation and care, and daily physician attention for patients who are acutely or seriously ill or injured (British Columbia, 1993, p. 11). It is acknowledged that other types of ‘hospitals’ such as psychiatric hospitals, rehabilitation hospitals, or extended care hospitals exist in the current Canadian health care system but these differ from acute care hospitals in that they provide services to patients who have chronic, as compared with acute illnesses.

Northern Interior Health Region (NIHR) of British Columbia - The NIHR covers the central-eastern area of British Columbia. The region follows the Yellowhead Highway
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It takes approximately seven hours to drive from the western to the eastern reaches of the region and approximately 3.5 hours from its northern to southern limits (see map in Appendix A). The economy of this region is based on forestry, mining, transportation, tourism, and agriculture. The population is younger than the provincial average and unemployment rates are higher than the provincial average. Mortality rates are among the highest in the province with alcohol related deaths, particularly among females, significantly higher than the provincial average. Hospitalization rates and teen birth rates are higher than the provincial average and immunization rates for infants are lower (British Columbia, 1993). It is noted in the 1999 annual report of the Provincial Health Officer that although northern regions of the province continue to have "the poorest health, based on measures available, ... the gap between northern and southern regions is narrowing" (British Columbia, 2000, p. 7).

In the NIHR there are six acute care hospitals. The largest of these facilities is the Prince George Regional Hospital (PGRH) located in the larger urban centre of Prince George (population ~80 000). As Prince George and the Prince George Regional Hospital do not fit with the definition of rural and small town noted above, it is not included in this research project. The remaining five hospitals in the NIHR are located in small rural towns. The village of McBride (population 580), is located 220 kilometres east of Prince George (ABC Communications, 1999). The acute care hospital in this community has eight beds (Sawyer, Seegobin, & Croft, 1997). The town of Mackenzie has a population of 5796 and it is located 190 kilometres north of the city of Prince George (ABC Communications, 1999). There are twelve acute care beds at the hospital in Mackenzie (Sawyer, Seegobin, & Croft, 1997). The town of Vanderhoof has a population of 4023 and it is located 100 kilometres west of the city of Prince George (ABC Communications,
There are 27 acute care beds at the hospital in Vanderhoof (Sawyer, Seegobin, & Croft, 1997). Fort St. James is a community with a population of 2209. The town is located on a secondary highway off the Yellowhead highway and is approximately 160 kilometres north west of Prince George (ABC Communications, 1999). The hospital in Fort St. James has 16 acute care beds (Sawyer, Seegobin, & Croft, 1997). The town of Burns Lake is the furthest community in the NIHR from Prince George which hosts an acute care hospital. The community has a population of 2126 and it is 229 kilometres west of Prince George (ABC Communications, 1999). The hospital in Burns Lake has 26 acute care beds (Sawyer, Seegobin, & Croft, 1997).
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Chapter 2

The Literature Review

What do we know about discharge planning?

As previously suggested, there is an abundance of articles written about discharge planning from acute care hospitals from a variety of perspectives. In this section, I will offer a summary of this literature particularly as it is presented in medical social work journals. Nacman (1990), in documenting the history of social work in health care, describes that the primary role of the very first hospital based social worker hired in 1903 at Massachusetts General Hospital was to “report to the doctors on the domestic and social conditions of patients, to help patients fulfill doctors’ orders, and to provide a linkage between the hospital and community agencies and organizations” (p. 10). In Canada, a 1910 press release of the Winnipeg General Hospital summarized by Busca (1989) depicts the hospital social worker as “one that looks after the material welfare of patients who are about to leave the hospital, that ensures that they shall live in proper hygienic surroundings, that they have proper clothing and food, and to arrange suitable occupations” (p. 36). Both portrayals describe in essence, discharge planning. The roles assigned to hospital social workers have evolved, expanded and been refined over the past century but these types of instrumental discharge planning activities have remained, for a large part, the basis of hospital social work activities (Nacman, 1990).

In the literature, there is relative consensus that discharge planning aims to ensure exit of the patient from the acute care hospital to a satisfactory discharge destination which offers acceptable levels of risk and strives to ensure a reasonable quality of life. What qualifies as offering ‘acceptable levels of risk’ and ‘reasonable quality of life’ are variables to be negotiated between physicians, hospital staff, and patients and their families. Many definitions of discharge planning exist. Definitions of the term frequently appear to be used
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interchangeably with descriptions of the process. For example, Blumenfield & Rosenberg (1988) describe discharge planning as an “interdisciplinary hospital-wide process that should be available to assist patients and families in developing a feasible post-hospital plan of care” (p. 38). Bull and Kane (1996) similarly describe that discharge planning is “an interdisciplinary process that assesses need for follow-up care and arranges for that care, whether the care is self-care, care from family, care provided by paid providers, or a combination of these options” (p. 486). Feather (1993) states that “hospital discharge planning is the process of assessing the needs of hospitalized patients for post-acute care and developing a co-ordinated plan to provide the care needed” (p. 1). Shulman and Tuzman (1982) define discharge planning as “a systematic, organised and centralised approach to providing continuity of care from the time a patient is admitted to a health care facility through return to the community” (p. 27). O’Hare (1988a) describe similarly that discharge planning involves “assessing needs and obtaining or coordinating appropriate resources for patients and clients as they move through the health care system” (p. 5). These are but a few of the available definitions.

At large urban based hospitals, discharge planning is often associated with the hospital’s social work department. This has not always been a role relished by social workers. The provision of concrete services, often important in discharge planning, tended to be perceived by social workers as less desirable and less professional than counselling tasks (Drolen & Harrison, 1990). As the pressure to discharge patients ‘sicker and quicker’ has increased, so has the importance of the discharge planning function. Both social work and nursing are now eager to engage in discharge planning functions. This has lead in some instances to what has been termed “turf wars” (Terry, 1988, p. 45) between the two professions. P. Bywaters (1991) in his article titled Social work and Nursing: Sisters or
Rivals? as well as Egan and Kadushin (1995) in their article Competitive allies: Rural nurses' and social workers' perceptions of the social work role in the hospital setting, explore this issue. The similarities in the professional preparation of the two groups and generally overlapping role expectations in the hospital setting foster these turf wars. Research indicates that it may not matter significantly which group leads discharge planning activities in a facility as long as it is clearly delineated (Terry, 1988). Recent trends include having both social workers and nurses work together on discharge planning under one departmental structure.

In urban hospitals a variety of health professionals participate in discharge planning. Physicians, nurses, social workers and other allied health professions such as occupational therapy, speech language pathology, nutrition, and physical therapy contribute routinely to the development of patient discharge plans. Much of the existing literature emphasizes the importance and in fact, necessity, of this multi-disciplinary or inter-disciplinary collaboration in the development of comprehensive and effective discharge plans. As noted previously, several existing definitions of discharge planning have the words 'interdisciplinary' or 'multidisciplinary' embedded in them. What happens in facilities where a range of staff does not exist, as in rural and small town hospitals, is not explored or even conceptualized as a possibility within the literature. Such an exploration will begin with the research project described hereafter.

Despite the relative consensus as to what the goals of discharge planning are, the need for interdisciplinary collaboration to accomplish it, and by definition that it is a process, there is no such consensus about what the process actually looks like. Thoms and Mott (1978), in their pioneering article on discharge planning, suggest that the process of discharge planning is to “coordinate and do primary planning, helping the patient and the family to consider placement alternatives thoroughly and carefully” (p. 38) and to offer “supportive counseling in
decision making [which] helps to relieve the sense of guilt that often accompanies the
decision” (p.38). McCarthy (1988) succinctly describes four components to the discharge
planning process. These are (1) assessment, (2) planning, (3) implementation and (4)
evaluation. McCarthy (1988) notes that “although the four components follow a logical
progression, there will often be two or more components in operation at any given time. The
process is cyclic, and between and among components there is constant movement” (p. 106).
Auslander and Soskolne (1993) describe the process of discharge planning as including five
key elements, (1) early identification and assessment of patients likely requiring discharge
planning services, (2) promoting patient and family understanding of the illness, its care and
consequences, (3) coordinating the multidisciplinary health care team’s discharge-related
activities, (4) identifying and coordinating the resources necessary to provide post-hospital
care, whether in the community or in another institution and (5) follow-up of discharged
patients (p. 100-101). Tennier (1997) writes from a social work perspective and
comprehensively describes discharge planning as:

a process involving several social work functions including high risk screening, social
work assessment, counselling, locating and arranging resources,
consultation/collaboration, patient and family education, patient advocacy and chart
documentation. It is a complex psychosocial activity which requires use of a wide
range of clinical and organisational skills to address the discharge related needs of
patients, their families, and the health care system. It is also an interdisciplinary
process which may begin prior to admission and which promotes optimum functioning
of patients, their families and support systems (p. 42).
The most specific articulation of what social work tasks are involved in discharge planning is presented by Kadushin and Kulys (1993). In their article titled *Discharge planning revisited: What do social workers actually do in discharge planning?* Kadushin and Kulys identify 73 discrete tasks typically involved in discharge planning. Results of their survey of social work practitioners suggest that the individual tasks involved in discharge planning do not require great amounts of time. Grouping the tasks into five categories of activities revealed in descending order, that time was spent on assessment, coordination, documentation, counselling and linkage activities. The importance of the activities were rated somewhat differently than their time allocations would indicate. The social workers rated in descending order of importance, coordination, assessment, counselling, linkage and documentation. Kadushin and Kulys (1993) conclude, as does Tennier (1997), that discharge planning as practised, is a complex process primarily involving the provision of concrete services with a recognition that counselling can be an important component. Some authors such as James (1987) however, differentiate between the ‘phases’ of discharge planning and the ‘modes’ of discharge planning. James (1987) identifies five phases of discharge planning. These are (1) screening/identification of patients in need of discharge planning services, (2) engagement with patients and interdisciplinary staff and data collection, (3) assessment, (4) plan development and implementation and (5) monitoring, evaluation and corrective action. James (1987) alternately describes three ‘modes’ of discharge planning. These are first, where no contact with a further service is anticipated and termination from acute care and anticipatory guidance is offered. The second mode involves referral and/or transfer of the patient to another service and third involves cases where patients are steered towards discharge service options but are not formally referred (p. 51). In such cases patients and/or families are required to
investigate and retain services they deem necessary. The modes describe the intensity of discharge planning services offered.

Other authors however, suggest that it is not the model of discharge planning followed which impacts a facility's discharge effectiveness, rather it is other factors. Feather (1993) suggests that "power and clarity rather than the model used or characteristics of the hospital, are the important factors in developing an effective program" (p. 12). Power, according to Feather is derived from discharge planning being supported by the physicians practicing in the facility and the hospital administration's support of the issue. Power is also vested in the discharge planner position and person by the physicians and administration. Clarity, results from the discharge planner's functions and the discharge planning process being clearly defined and documented within the organization (Feather, 1993).

Despite the differing descriptions of the process of discharge planning, Rossen and Coulton (1985) suggest that there is in fact "a high level of agreement about the basic components of a good discharge planning program but there is insufficient research to confirm many of these assumptions. Some of the program elements that are uniformly seen as desirable and necessary are: formalization of the function with an assigned discharge planning coordinator; screening; patient/family self-determination; comprehensive assessment; and follow-up" (p. 56-57). Dill (1995) suggests that there are three features distinctive of discharge planning in major medical centres. These are "the division of authority along both departmental and professional lines; the discharge planners' dependence on actors and organisations in the external environment; and tensions between the bureaucratic need for routinization and efficiency, on the one hand, and dynamic and pragmatic factors constraining the ability to standardize the discharge process, on the other." (p. 1293). Within this context, discharge planners attempt to "enhance their own autonomy, to develop tacit understandings
and other means of shortcutting work requirements, and to promote consensus among their professional colleagues” (p. 1293-1294). In the United States, discharge planning is formalized under Medicare guidelines. The sanctioned process must include identification, evaluation, a formal written discharge plan, continuity of information transfer and reassessment to be performed by an interdisciplinary team (Wertheimer & Kleinman, 1990, pp. 837). In Canada, no national or provincial standard has been likewise adopted.

Despite the focus on discharge planning, particularly over the past two decades, it does not yet appear to be a process that has been perfected. Wolock, Schlesinger, Dinerman and Seaton (1987) in reviewing the literature to their time note that “after discharge substantial proportion of patients experience problems in a number of areas, including financial difficulties, housing problems, psychosocial problems such as family adjustment, difficulty following medical regimen and other health-related problems” (p. 63). This study found that for nearly 90% of discharged patients “not only did family members assume the major responsibility for posthospital care but that this was provided at some cost to their own well-being” (p. 70-71). Soskolne and Auslander (1993) unexpectedly found that increased training in ‘comprehensive’ discharge planning for hospital social workers did not lead to increased patient satisfaction postdischarge but rather less. The authors speculate that due to the large responsibility families have in providing post-discharge care, discharge planning processes must adequately prepare families for their caretaker role and plans must contain methods of providing continuous support and relief to these informal caregivers. Bull and Kane (1996) suggest that particularly, for older patients, discharge planning continues to result in “unmet needs of elders, difficulties managing care and hospital readmissions indicate that problems persist” (p. 486).
In summary, the existing literature suggests a relative consensus regarding the goal of discharge planning which is to assure that patient needs are met upon discharge from an acute care facility. There is also relative consensus that discharge planning is a process which requires early identification of patients requiring discharge planning, interdisciplinary assessment, planning, co-ordination, implementation and follow-up. It is suggested by several authors that a ‘boundary-spanning’ discharge coordinator is important to the success of the discharge planning program. Despite these understandings, patients continue to experience unmet needs after discharge from hospital.

What do we know about discharge planning at rural and small town hospitals?

As stated previously, little existing research examines exclusively the process and practice of discharge planning at rural and small town hospitals. The literature discussed in the previous section is based on urban hospital experiences, and most often, large university affiliated teaching hospital experience. This represents a geographic bias in the existing literature. As discharge planning at rural hospitals has not been widely examined, it is not known what, if any, differences exist between small community hospitals and their urban counterparts with regards to discharge planning. Screffler (1996) suggests that “rural [health] care services and the environment interact with one another and through this interaction, over time, partially determine one another” (p. 49). From this ecological perspective it can be extrapolated that the discharge planning services in small community hospitals are influenced by the community context and how discharge planning occurs influences how the community is set up to support discharged persons. This recursiveness may also occur in urban environments but dissimilarities between urban and rural contexts likely result in unique outcomes or adjustments being made. In this way the discharge planning process in small communities is expected to differ from processes utilized in urban environments. Clark,
Chumbler and Nadzam (1994) suggest, based on resource dependency theory that “hospital and community environments are likely to affect the discharge planning process through discharge planners’ perceptions of the adequacy of resources” (p. 267). Hospital characteristics which they hypothesize may effect discharge planning include “the size of the hospital, budget constraints, service/personnel availability, staff training levels, and staff-to-patient ratios” (p. 270). As one of the basic tenets of discharge planning described above relies on interdisciplinary or multidisciplinary involvement and knowing that small rural hospitals often do not employ a wide range of professionals, it can be assumed that differences do exist.

Community characteristics include the existence or non-existence of formal home care services such as “adult day care, respite care, counselling, guardianship, and material aid” (p. 270).

Results of the Clark, Chumbler and Nadzam (1994) survey in the United States suggests generally that rural and inner city hospitals perceive a lack of adequate formal community services and rely more on informal caregivers than do urban/suburban located hospitals. The authors suggest that “informal caregivers be integrated into the discharge process so that all are receiving some information or training in postdischarge care.” (p. 279). Post discharge follow-up may also be more important for these informal caregivers. Bull and Kane (1996) similarly report that “with fewer resources available in rural areas healthcare providers needed to expend extra effort in developing and coordinating informal resources” (p. 492). Egan and Kadushin (1995) suggest similarly that rural hospitals are “discharging patients ‘sicker and quicker’ to communities which lack adequate community resources, such as day care, foster care, homemaker services and nursing homes” (p. 15-16) and in this context “procurement of scarce community resources” (p. 16) becomes an important component of the discharge planning process. Egan and Kadushin (1997) suggest that it is not only the lack of formal community resources in rural areas which impedes discharge planning but rather it is “the weakening of
extended family as young adults leave for opportunities in urban locations” (p. 14) combined with the lack of formal services which causes difficulties. Screffler (1996) similarly states that the “outmigration of young adults have resulted in a higher proportion of elderly people than in urban areas” (p. 52). In addition to hospital and community characteristics, individual patient characteristics must be recognised as having important implications for the discharge planning process and outcomes. From an ecological perspective, individuals can also be, in part, viewed as a product of their environment and thus differences between individuals from small community/rural environments and urban environments can also be anticipated.

Other potential differences between urban hospital discharge planning and rural hospital discharge planning have been suggested. James (1987) states

discharge planning in small country hospitals where patients are often well known, is likely to raise special problems in confidentiality and to modify emphases on case finding, exploration and engagement phases, creating a more informal “local community” style of discharge planning. (p. 58).

Arundel and Glouberman (2001) in researching the transfer of patients from acute to home care services suggest that “clearly some differences in discharge between patients living in rural areas and those in urban areas” (p. 35) exist. Although rural discharge issues were not a focus of the report, Arundel and Glouberman (2001) found that “distance, weather, access to supplies and equipment, access to acute care hospitals, access to community supports and care professionals and access to basic services like water, roads, telephone, etc.” (p. 35) were all barriers to effective discharge planning for residents of rural and remote areas of Canada.
These authors also suggest positive impacts of the rural setting on discharge planning. They note that

rural settings demonstrate a greater capacity to coordinate and collaborate on discharge planning. This is partly because individuals involved in the health care system know each other and are required to work together on an ongoing basis and also because there is less specialization and bureaucratization in the smaller health care settings. (p. 79).

The authors go on to identify that smaller health care systems "are able to rely to a greater degree on mutual adjustment and formal and informal networks. Larger systems face greater challenges in developing and maintaining relationships and processes that lead to consistent system-wide best practice" (p. 38). These "relationships and informal networks are important to bridge gaps between the formal systems and extend the effectiveness of the discharge practice" (Arundel & Glouberman, 2001, p. 39).

As is apparent, it is suggested in the literature that the rural environment creates both positive and negative effects on discharge planning at small community hospitals. Due to the lack of formal research in this area however, these beliefs remain unsubstantiated. How discharge planning is accomplished, what factors, realities or circumstances of small communities influence the process and how successful it is, has not been explored. Research into the area of discharge planning from small community hospitals is warranted.
Introduction

A fundamental question every researcher must ask themselves when embarking on a research project is “what is my research question and is it best answered using qualitative or quantitative methods?” The research question explored in this study is “how is discharge planning accomplished at rural and small town hospitals within the NIHR of British Columbia?” The answer to this question is necessarily descriptive which lends itself to qualitative versus quantitative modes of inquiry. Bull and Kane (1996) state that the “purpose of qualitative data is to provide insights on the nature of problem, rather then produce generalizations based on a representative sample. The insights can generate possible solutions” (p. 486). Enhancing the discharge experiences of residents of rural and small towns using their local acute care facility is a desire of this research.

Creswell (1994) lists six basic characteristics of the qualitative mode of inquiry. These are:

(1) Qualitative researchers are primarily concerned with process, rather than outcomes or products.

(2) Qualitative researchers are interested in meaning.

(3) The qualitative researcher is the primary instrument for data collection and analysis.

(4) Qualitative research involves fieldwork (i.e. going out to people, settings).

(5) Qualitative research is descriptive.

(6) The process of qualitative research is inductive in that the researcher builds abstractions, concepts, hypotheses and theories from details. (Creswell, 1994, pp. 145).
The research described in this thesis displays all of these characteristics and will be detailed in the sections that follow.

The Research Design

Sampling

Kuzel (1999) suggests that sampling decisions must attend to two issues of quality; appropriateness and adequacy. To ensure appropriateness, researchers must consider how the selected sample fits into the research purpose and the phenomenon of interest and the sampling strategy employed should be consistent with the style of inquiry (Kuzel, 1999, p. 45). Kuzel (1999) suggests that purposive sampling in qualitative studies is common and desirable as, sampling is not driven by a need to generalize or predict, but rather by a need to create and test new interpretations. Typically, the investigator wants to increase the scope or range of data exposed to uncover multiple realities and/or to create deeper understanding” (p. 34).

Similarly Grbich (1999) suggests that “qualitative researchers usually employ non-probability techniques ... [which] are not representative. Their purpose is to select information-rich cases” (p. 69). Adequacy of a sample relates to the sample size. Kuzel’s (1999) recommendation is that “although there are no hard and fast rules, experience has shown that five to eight data sources or sampling units will often suffice” (p. 42).

In this study two distinct, but related, purposely chosen samples are utilized to explore the question of discharge planning at rural and small town hospitals. Obtaining the first sample involved choosing rural, small town sites that had functioning acute care hospitals. The five small communities in the NIHR which had such facilities were chosen as an adequate yet
convenient sample of such sites. Each of the sites chosen fit the definition of a rural and small town as defined by Statistics Canada (2001) and all are within three hours of the researcher's home.

The second type of purposive sampling used in this study involved deciding who should be polled for their experiences regarding discharge planning at small town hospitals. Miles and Huberman (1994) suggest that in studies such as this one, people are sampled “to get at characteristics of settings, events, and processes. Conceptually, the people themselves are secondary” (p. 33). The selection of appropriate participants was based primarily on the researcher’s practice knowledge that in the small community hospital setting there are three key participants in the discharge planning process. These are the attending physicians, the nurses at the hospitals and the patients themselves. Terry (1988) suggests that “the physician’s role in discharge planning in the past and, to a lesser extent, the present has been that of gatekeeper to the health care system” (p. 45). Physicians have the sole authority to admit patients to hospital and to discharge them as well. A discharge plan is in essence ratified by the physician in the act of writing a discharge order for a patient. The plan can conversely, be vetoed by the non-writing of such an order. It is the physician’s responsibility ultimately to ensure that a discharge plan is adequate to meet a patient’s needs. Due to this integral role, physician opinions, beliefs and perspectives are important in gaining an understanding of the discharge process at small community hospitals.

Nursing representation likewise provides a valuable perspective on discharge planning. At small community hospitals nurses are the predominant professional employee with whom patients have contact. Nursing contact with patients is continuous and nurses are primarily responsible for assessing patient needs and developing discharge plans. This is done with the intimate knowledge of available community resources, both formal, and informal. Due to the
dominant role of nursing in small community hospitals, the opinions, beliefs, and perspective of these professionals is very important to understand how discharge planning occurs at these facilities.

The recipient of discharge planning services is by definition, the patient. How well a discharge plan succeeds at meeting a patient's needs can best be described by the patient. For this reason, the thoughts, beliefs and experiences of recently discharged patients were sought. To enhance comparability of experiences across sampled patients, characteristics of the patients were further purposely specified by the researcher. The types of recently discharged patients sought for inclusion in the patient sample were competent elderly (over 65) persons, able to converse in English, who had been admitted to hospital with a primary orthopaedic diagnosis or a general medicine diagnosis. This type of patient was selected because of the researcher's practice knowledge that such patients routinely pose challenging discharge planning issues. Often these challenges are related to a lack of or unavailability of family or other informal persons to assist some elderly persons. This practice knowledge has been similarly identified in the literature (see Bull & Kane, 1996; Kadushin & Kulys, 1994; Lammers, 1992; Sulman, Rosenthal, Marshall, & Daciuk, 1996; Wolock et al, 1987). The decision to interview patients as opposed to family members or friends of elderly patients was also purposely made. It has been suggested in the literature that family members do not necessarily view discharge planning and discharge outcomes the same as the patients do. Weaver (1994) in a review of the literature concluded that “data suggest that a proxy or surrogate decision maker may not adequately represent a patient's wishes in discharge planning” (p. 399). Showers, Simon, Blumenfield and Holden (1995) similarly found that “while no difference was found between overall patient and proxy ratings of discharge plans, substantial differences were found in explanations of satisfaction for the two groups” (p. 29).
The potential discrepancy between patients and family members perceptions of discharge planning along with the researcher's assumption that some of the former patients would likely not have family available and willing to participate, lead to the decision to interview patients exclusive of family members.

In this research, each of the three key participants identified above were selected to act as key informants regarding the discharge planning process utilized at each of their small town hospitals. It is important to note that the term 'key informant' is not used by all researchers/methodists. Patton (1990) for example, refers to such sampling as critical case sampling and suggests that it involves choosing people who will provide the most information on a topic. Gilchrist and Williams (1999) offer that any person who shares information is an informant, but a key informant differs from other informants by the nature of their position in a culture, their information-rich connection to the research topic, and by their relationship to the researcher ... [key informants] have access to perspectives or observation denied the researcher through other means ... it is the informant's interpretation of information that is critical (p. 73).

Gilchrist and Williams further suggest that the selection of key informants represents nonprobability sampling, referred to as purposeful, strategic, or information-rich sampling ... the selection attempts to yield a small number of informants who provide information-rich pictures of aspects of information or knowledge distributed with the study population (p. 76).
The selection of one physician, one nurse and one recently discharged patient to act as key informants does address the appropriateness quality dimension posed by Kuzel (1999). These key informants across location come to form homogeneous key informant groups. Kuzel suggests that with regards to an adequate sample size “when there are subgroups, the ‘five to eight’ rule applies to each group” (p. 42). In this study, subgroups of five physicians, five nurses and five patients were formed. Grbich (1999) suggests that researchers pursuing a rigorous method engage in triangulation of data and/or data sources to ensure completeness or for “the achievement of holistic information regarding a phenomenon” (p. 61). Gilchrist and Williams (1999) similarly note that triangulation is one method of increasing the validity of qualitative research. The design and utilization of three subgroups in this research supports triangulation of the data by source. In this research, triangulation is done in order to obtain a more comprehensive view of the subject and as Grbich notes to enhance the rigour of the methodology and validity of the results. Triangulation as a methodological approach is however, not without critics. It has been suggested that gathering “information from different points (methods and sources) may not serve to consolidate a certain position. It may simply provide more information for the researcher to deal with” (Grbich, 1999, p. 62). In completing this research, I would suggest that both are true. The triangulation methodology used in this research in conjunction with adhering to the minimal sample size suggested by Kuzel (1999) resulted in 15 interviews being conducted which did result in much data being generated for the researcher to analyze. As unique themes were generated by each of the three subgroups utilized in the triangulation, information would have been missed if the three-way triangulation methodology had not been employed. Details on the results of this study are detailed in the following chapter.
Data collection

Data collection methods in qualitative research vary. Document review, questionnaires and interviews are predominant methods. Interviews with participants can be unstructured, semi-structured or fully structured depending on the degree to which the interview is guided or controlled by the researcher. Grbich (1999) notes "the aim of conducting interviews is to gain information on the perspectives, understanding and means constructed by people regarding the events and experience of their lives" (p. 85). Reinharz (1992) similarly describes that "interviewing allows interviewers to envision the person’s experience and hear the multiple voices in a person’s speech (p. 39). Miller and Crabtree (1999) point out that

the depth interview is a powerful qualitative research tool when the focus of inquiry is narrow, the respondents a clearly defined and homogeneous bounded unit with an already known context, the respondents are familiar and comfortable with the interview as a means of communication and the goal is to generate themes and narratives (p. 90).

In this study, interviews were chosen as the method of obtaining data because of the nature of the information sought by the researcher and because the author wanted to hear the voices of those involved in, and affected by discharge planning directly. Interviews were conducted with one of each type of participant (i.e. physician, nurse or patient) in each of the five small communities of the NIHR hosting acute care hospitals. Specifically, a semi-structured interview format was chosen as specific areas of interest to the researcher needed to be included in each interview. Asking the same questions of various participants allowed for comparison of responses between participants. The predetermined semi-structured interview format was similar for each type of participant but unique as well (see Appendixes H, I, J for
interview questions). The questions were based in part on questions posed by Arundel and Glouberman (2001) in their national survey investigating blockages in the effective transfer of acute care patients to home care, but most are solely the researcher's and are based on her current practice experience as a hospital social worker within the region.

Recruiting participants

Prior to recruiting participants, progressive levels of approval were needed to ensure the acceptability and ethics of the research. Initially, senior hospital administrators were sent letters introducing the project (see Appendix B for letter of introduction). Follow-up telephone calls placed by the researcher confirmed that the administrator had received the introductory letter, and verbal consent for their facility to participate in the research was requested and obtained. This followed with the administrators writing letters of support for the research which were necessary in order to obtain NIHR research review committee support (see Appendix C for NIHR approval confirmation). In succession, NIHR support was needed to obtain University of Northern British Columbia (UNBC) ethics review support (see Appendix D for UNBC ethics approval). The total elapsed time for obtaining clearance from all levels to proceed with the research was nine weeks.

Each type of key informant (i.e. physician, nurse or discharged patient) was recruited separately to participate in the study. Physician participants were recruited directly by the researcher. Initial letters of introduction and request for participation were sent to all physicians in each community (see Appendix E for letters of introduction for physicians). Names and addresses of the physicians were obtained from the local hospital. One physician in one community responded to the researcher's initial written request and indicated that he/she would not be available to participate. That physician's name was not included in the subsequent draw for telephone follow-up by the researcher.
Approximately two weeks after the initial letters were mailed to the physicians, the names of the physicians in each community were placed in a hat and one was randomly selected for telephone follow-up by the researcher. In four of the communities, the first physician contacted by telephone agreed to participate. In one community, the first physician contacted declined participation but the second physician agreed. As interest in participating in an audio-taped interview was expressed, a time and date was set for the interview.

Interviews with the physicians were most typically scheduled during the mid-day lunch break. Four out of the five physician interviews were conducted at this time, at their clinic office. One interview occurred on a weekend and was conducted at the physician’s home. The physician subgroup had both male and female participants. Three of the physicians had immigrated to their current communities from countries outside of Canada. The two remaining physicians were originally from, and trained in Canada. The number of years practising medicine in the current community ranged from 3.5 to 34 years. For the physicians, establishing researcher credibility was important prior to engaging in the interviews. It is suspected that this was an issue because the academic field for which this research was being completed (i.e. social work) is outside of what is normally considered the medical or health fields. Knowledge that the researcher had understanding of the medical system, hospital functioning and patient issues was important to the physicians. Researcher credibility was established by revealing that the author practices social work at the regional referral hospital. Some of the physicians were aware of this fact due to previous contact. It is not clear if physician recruitment would have been as successful had the author not had this personal background.

Nurse participants were recruited indirectly by the researcher. The administrators of the small town hospitals who had indicated support for the research were asked to identify two
or more experienced nurses at their facility willing to participate in the study. From this pool, the researcher had planned to randomly choose one nurse for participation. It can be assumed that some bias was present in the administrators’ selection of nurses to participate. This bias was to be controlled by having administrators provide the names of three possible nurse participants and then the researcher would randomly select one to interview. In reality, only two facilities complied with the request to provide multiple names. The remaining three facilities provided the name of only one participant. It is possible that only one nurse volunteered or perhaps only one was asked. As a note, one facility identified two nursing participants who wished to be interviewed together and this request was accommodated.

Issues of confidentiality and anonymity become complicated when a third person is involved. The participants were asked by the researcher to respect the confidential nature of the discussion but compliance to this request can not be assured by the researcher.

Upon being identified by the hospital administrator, the potential nurse participants were contacted by telephone by the researcher. The purpose of the telephone contact was twofold. First, to explain the research project fully to the nurses including their role in recruiting patient participants and second, to confirm their willingness to participate in the research. All of the nurses telephoned agreed to participate. Of the nurses interviewed, four chose to be interviewed at their small town hospital. Three were not working at the time of the interview and one was. The two nurses who wished to be interviewed together were interviewed at the Prince George airport as they were needing to catch a flight and had some time to wait and it was convenient for them and the researcher. The interviews with nurses ranged from one hour, five minutes to one hour, twenty-five minutes. The number of years working at their small community hospital ranged from 1.5 to 20 years for the nurses with the mean being 11 years. The nursing group had both male and female participants.
The recruitment of former patients was done through the nursing participants in the study. As with the selection of nurse participants by the hospital administrators, it can be assumed that some bias was present in the selection of patients as some were selected over others. It is not known for sure what this bias may be and perhaps it was different for each nurse. It was unexpected by the researcher that all of the patients interviewed would have well developed informal support systems and particularly, available and involved family support. The patient selection criteria set by the researcher was thought to favour identification of patients without such supports. One community could provide no names of patients meeting the age criteria set by the researcher as very few seniors live in the town. The town itself is only approximately 30 years old and was created as an instant town to house the labour force needed for pulp mills which were started in the area at that time. In this community a 49 year old patient was accepted for interview. This particular participant lived alone and suffered from a condition which limited his/her strength and mobility. These are issues known to make discharge planning for the geriatric population difficult and thus similarity to other participants was maintained.

Introductory letters intended for patients (Appendix F) were forwarded to each nurse weeks prior to any interviews being anticipated. It had been planned that nurses would distribute the letter to patients meeting selection criteria as previously described and be available to answer any questions which patients may have had. If patients were interested in participating in the research, they were to sign the bottom of the letter and return it to the nurse. After five such letters were returned to the nurse, they would then be forwarded to the researcher and one patient would be randomly selected for interview. This design however, proved too cumbersome and the provision of one discharged patient name per facility by the
nurse was accepted as sufficient. Two communities were however able to provide two or more patient names from which the researcher was able to randomly choose one person to interview.

Patient consent for the nurse to reveal their name and address to the researcher was most typically gathered by the nurse verbally. In two instances, this consent was obtained in writing. In receiving the former patient's name and telephone number from the nurse, the researcher placed a telephone call to the patient. This telephone call, as with the nurses, was to fully explain the research to the discharged person, and to confirm interest in participating. Each former patient contacted provided verbal consent to the researcher for participation and a time and date of their choosing for the interview was set. To note, one former patient participant was recruited by their family member who was aware of the research and wanted to participate. Of the five interviews conducted with former patients, four occurred at the patient's home in or near the small community hosting the acute care hospital. One interview occurred in the larger regional centre as the patient had gone there to stay with a relative in order to obtain needed health services. In all instances family members of the patients were present during the interview and some of their views were recorded as well. Patient interviews ranged in duration from 55 minutes, to 1 hour, ten minutes. Of the former patients interviewed, four of the five were between the ages of 66 and 88 years. One, as noted previously was 49 years of age. Of the five former patients, two were widowed and typically lived alone. One was widowed and resided with a son. One participant was married and lived with his/her spouse and one was never married and lived alone.

Assuring informed consent and confidentiality

At the time of each interview, but prior to commencing the same, this researcher provided an explanation of the research; the purpose, methodology and potential outcomes. At that time a description of how confidentiality and anonymity of the participants would be
maintained by the researcher was provided. Participants were told that the audio-tapes of the interviews were labelled in code and that neither their name, nor the name of their community would be documented. Participants were told that verbatim transcripts of the tapes would be produced for analysis purposes but any reference to a specific community or person would be eliminated. A specific community name for example would be replaced with the words ‘community name’. Similarly, specific persons referred to would be identified by their relationship to the patient. For example if a patient spoke about Dr. Smith, that name would be replaced with ‘family doctor’. It was explained to each participant as well that audio-tapes and transcripts would be maintained in a secure location at the researchers home for a period of two years and then destroyed. Each participant was asked to read, or in cases where reading was obviously difficult, the researcher read a formal written consent for participation form (Appendix G) which conformed with and had been approved by the UNBC ethics review committee. The information presented orally by the researcher was repeated on the written consent form. Repetition was used to enhance participant comprehension of the research and thus ensure informed consent. The participants were invited to ask questions and if no concerns were indicated, they were asked to sign the consent for participation form which the researcher retained. None of the participants expressed concerns regarding how confidentiality and anonymity of the participants was to be safeguarded by the researcher and all readily signed the consent for participation form.

_Supplementary data_

In addition to the interviews conducted with participants, an additional data source was used. Immediately after each interview the researcher recorded her own observations, thoughts, and perceptions of the interview in a separate journal. The entries in this journal are coded with the same code as the tapes and transcripts to ensure that anonymity is maintained.
but also so that it is clear which interview the entry refers to. These supplementary data were used during the analysis phase of the research to help flush out and clarify emerging themes presented by the participants. A description of these themes is presented in the following chapter.

Data analysis

A wide variety of data analysis methods are utilized in qualitative research. Tesch (1990) states that a descriptive/interpretative analysis of qualitative data involves two different operations. First, “you must somehow divide the text into segments, and then you must sort these segments into groups” (p. 114). Tesch refers to the process of separating portions of data from their original context as ‘de-contextualizing’. Tesch suggests that data segments to pull out must be relevant to the research question and should be “a segment of text that is comprehensible by itself and contains one idea, episode or piece of information” (p. 116). These segments of pertinent data can be referred to by a variety of names e.g. data bits, meaning units, analysis units, items or themes. In this current research they are referred to as themes.

The process of regrouping individual themes into broader categories Tesch (1990) refers to as “re-contextualizing” (p. 115). The process of re-contextualizing Rubin and Rubin (1995) alternately refer to as coding, and state that “coding is the process of grouping interviewees’ responses into categories that bring together similar ideas, concepts, or themes” (p. 238). Dey (1993) likewise describes that in qualitative data analysis “we don’t just break the data up into bits, we also assign these bits to categories or classes which bring these bits together again” (p. 44). Tesch (1990) notes that the utility of re-contextualizing themes into thematic categories differs between interpretative/descriptive research and theory building research, “in interpretative/descriptive analysis, categories are used as an organizing tool; and
in theory-building analysis, categories start out as tools and become part of the outcome” (p. 139). In summary, Tesch notes “arranging one’s categories is merely a convenience to provide an overview over an otherwise unwieldy number of individual categories” (p. 140) or themes.

In this current descriptive research on discharge planning, the data to be analyzed originated in the interview transcripts. Each participant’s interview was audio-taped and transcribed verbatim with the aforementioned alterations to ensure anonymity of the participants. As the themes generated at individual communities by individual participants were not of primary concern in this research, completed transcripts were grouped by key informant type. This created groupings of five physician transcripts, five nursing transcripts and five former patient transcripts. Analysis began by reading all transcripts within one group in order to gain a global view. Transcripts were then re-read and potential themes de-contextualized. This was done inductively as it was not known what themes may be presented. The de-contextualized themes from each transcript were then read along with the researcher’s journal entry of the interview to solidify and flesh out the themes which were then redocumented. This was completed for each transcript. Themes from each transcript were then analyzed in comparison with the themes present in the other transcripts from that key informant group. Similar themes across key informants within a group were then grouped together or re-contextualized into categories of themes or thematic categories. These categories are presented narratively in the following chapter for each key informant group. A more detailed depiction of generated themes and thematic categories are presented by key informant group in Appendixes K, L, and M. The presence of individual themes were compared across key informant groups in a secondary analysis. The result of this comparison is also presented in the following chapter.
Introduction

In this study, the views of physicians, nurses and former patients were solicited with regards to how discharge planning was accomplished at their rural and small town hospitals. Data analysis was approached in two ways. First, themes were identified from individual transcripts and then grouped into meaningful categories. The results of this analysis are detailed by key informant group in the first part of this chapter. Secondary analysis involving a comparison of themes across key informant groups was also conducted. Results of this analysis are reported in the latter section of this chapter.

Data analysis in this research proved challenging for three primary reasons. (1) The sheer abundance of data to analyze and subsequent themes generated. (2) The internal homogeneity of themes within a group of key informants appeared disrupted by specific community influences. For example, one town which was built as an “instant” town in the 1970s had population demographics that were different than all other communities. Specifically, as very few senior citizens live in this community, any discussion of “seniors issues” was irrelevant yet these issues were very important in the other communities. Similarly, two of the hospitals/communities were greatly influenced by the presence of several First Nation reserves nearby and themes generated in these locations reflected this reality. In these instances the themes identified were noted with the realization that the theme was not expressed by all members of the key informant group. (3) The third challenge resulted from the unique perspective offered by each of the key informant groups. Physicians and nurses, as participants in the health care system, were much more able to comment on processes and resources utilized to accomplish efficient and effective discharge plans. Former patients as
Consumers of the health care system were only able to comment on what happened with them specifically. Due to their lived experience, discharged patients were better able to comment on the outcomes of discharge planning. The nuances of each group will become evident in the following section as themes generated are presented by group. As noted earlier, to focus the data for readers, related themes are grouped together into broader categories. These categories are not entirely mutually exclusive and must be taken in context with the other categories presented for that key informant group. Narrative excerpts taken directly from the transcripts are provided to give the reader the opportunity to hear the participants' voices and to provide clarification of the themes presented.

Themes of the Physician Key Informant Group

Nineteen individual themes were identified within the physician key informant group. These themes can be summarized as relating to the categories of (1) the physicians’ perception of discharge planning at the local hospital, (2) perceived strengths of the hospital/community at facilitating discharge planning and (3) characteristics of the hospital/community which negatively impact discharge planning. Details of these categories are offered below.

1. Physician perceptions of discharge planning at the local hospital.

All of the physicians interviewed were aware that the aim of discharge planning is to ensure that a patient has adequate supports in place to manage at home, away from the acute care facility. One physician noted, "I feel that people heal better at home so I always push to have people out as soon as plausible". All of the physicians interviewed acknowledged that some type of discharge planning process existed at their local small community hospital but most noted, quite candidly, that they did not know or were not aware of the specifics of policies or procedures which may be in place or who even who might be responsible for doing what. They were aware however, that planning was done, referrals were made and items and
services were put in place for patients to enable them to manage at home. All noted that attaining medical optimization of the patient was the primary physician contribution to discharge planning. As one physician noted succinctly, “well, I see it [planning for discharge] medically”. All were aware that as physicians they had the sole authority to discharge a patient from hospital.

Discharge plans were described by the physicians as being made jointly by them, the hospital nurses and other hospital staff (as available). In some communities this joint commitment to discharge planning was perceived positively by the physicians while in others it was perceived as being a difficult thing to engage in. Overall, the discharge planning process utilized at the rural and small town hospitals were described as relatively informal and flexible. The following two quotes illustrate this point:

I think that there is also a greater informality with regards to decision making and so on. In terms of discharge here, you are discharging without protocols and although we probably shouldn’t, we’ll keep someone another day because the family have gone out hunting or something and they won’t be back until tomorrow and we can’t send them home without that support.

We also have our own meetings over at the hospital, more or less on a daily basis, where we meet with the nurses who are on duty over there, they are asked for their concerns, I ask for their input, and I’m asked for mine and we just sit around the table and chat about it, to decide what we think is the best way to approach it.
The physicians interviewed indicated a reliance on the hospital nurses to enact a discharge plan or to coordinate and ensure that referrals were made and services put in place for patients being discharged. One physician commented that “I honestly wouldn’t be able to say who is doing exactly what [with regards to what services are provided by which community agencies], but I know that the nurses are tied in to that”.

It was noted by the physicians that although discharge planning had assumed a greater level of importance in recent years, it remained typically a non-urgent matter in their small community hospital. One physician stated “we are a little lax here. Discharge planning isn’t so urgent”. The reason given for this is that the small community hospital’s beds are not typically fully occupied and thus finding or making room for newly admitted patients is not a driving force in the hospital. It was noted however that the increasing scarcity of nursing personnel put a different kind of pressure on the hospital beds. One physician said “I have to say that in the last five years I was only pressured once for beds but often we are more pressurized for staff where we don’t have staff to take care of the patients”. If nursing staff are not available to provide care, patients must be discharged or transferred to alternate facilities.

2. **Perceived strengths of the hospital/community at facilitating discharge planning.**

Each of the physicians interviewed identified characteristics of their local hospital and community which they perceived to facilitate effective discharges for the patients leaving the acute care hospital setting. Each physician stated that the nature and approach of the small community hospital to discharge planning facilitated efficient and effective patient discharges. The reality that hospital occupancy is not typically to capacity, results in discharges being less pressured. Patients are allowed to remain in hospital until it is relatively certain that they will manage at home. As one physician noted, if it did not appear that someone would manage at home with the supports available “then I just keep them. One of the nicest things about being
in a small town is that I don’t have that big bad ugly bed supervisor looking at me”. It was noted that the hospital itself frequently acts as a support or resource for discharged patients. One physician described that he/she frequently asks patients:

to come back to the emergency room to get treated as an outpatient, so sometimes they receive outpatient treatment in the emergency room so it is not totally, only an emergency room. Dressings. We often have people come back for dressings to the emergency room or medications. Sometimes I arrange a follow-up as an outpatient in the emergency the next morning or in my office as soon as possible. I just make sure that they get a contact.

The physicians interviewed also suggested that closer or more familiar personal relationships exist between physicians, nurses, and patients in the rural communities and these relationships were believed to enhance the discharge planning engaged in at these facilities. One physician said “in a small town you just know the issues, you know the people, you know the patients, you know the workers” and with this knowledge “the comfort level of being able to talk to people, just to say to them, ‘what is the situation?’” is present. Another physician elaborates and states:

I suppose, the kind of, you know, closer relationships, between patients and the nursing staff. They know the patients so if someone is kept in hospital for a week goes home and then comes back in a week time, they know the history and they can pick up where they left off and say ‘hey, what’s been going on?’.
Another physician expands on the relationship between the family physician and their patients in a small community.

We do everything, from chronic to acute to people’s banking, to their marital problems, job problems, financial problems and these just come to you. I heard one of my partners yesterday through the door saying, ‘well I’m not a lawyer but...’. You give advice for all different spheres, so I think there is a different relationship”.

Other themes which are perceived strengths of the hospital/community at facilitating discharge relate to the utilization of existing formal services. Each physician interviewed viewed home care nursing services as exceptionally valuable. In all of the communities home care nursing personnel acted as the direct referral path to provincial long-term care services such as personal and home care assistance in a person’s residence, assessment, waitlisting for long term care facility placement, community rehabilitation services, adult day care (if available), and respite care. In three of the five communities the home care nurse(s) had the dual roles of being the home care nurse and the long term care assessor in a combined position. In the remaining two communities, home care nursing acted as a conduit to the designated long-term care assessor who could initiate these home support services. Many other community-based services were described as being important supports for patients, depending on patient circumstance. Specifically mentioned formal support services included diabetic day care, public health nursing, town counselling services, alcohol and drug counselling services, Meals-on-Wheels, Lifeline, Red Cross Medical Loan Service, RCMP Victim Services, and the Workers’ Compensation Board.
Informal support systems were also identified by the physicians as being important community features which support discharge planning. Family, friends, neighbours, church and community groups were specific supports identified in this theme. One physician suggested, “we’re pretty stoic here. People are used to just, no [formal services]”. The same physician goes on to describe the community:

It’s a very helpful community in that neighbours help each other. ‘I hadn’t seen John for a while so I just pounded on the door and he had fallen down’. Stuff like that. Friends are quite good. It’s a tight community so their neighbours will keep an eye on them and their families will keep an eye on them.

Another physician elaborated:

In a small community you often have the friends and the neighbours, the church and that kind of support. It depends on how involved people are in the community itself as to how much support they get. If they are active in the community they will get a lot of support.

3. **Characteristics of the hospital/community which negatively impact discharge planning.**

Within this category, nine themes as generated by the physician key informant group are combined. Some of the themes are respective of the small hospital and some relate to the small community context and the services offered there. The predominant theme of the physicians regarding characteristics of their local hospital which negatively impact their ability to facilitate discharge was the lack of specialized allied health professionals on staff. Such
staff include rehabilitation therapists such as physical, occupational and speech therapists, dietitians, pharmacists, and social workers. In all of the facilities, mobilizing patients to the point where they could independently maneuver around their homes, a necessary precursor to discharge, became primarily a product of nursing intervention. One physician notes “I think our girls [nurses] do all right, but they are not experts at these things”. In another community the physician notes “they [nurses] do a good job, as good as they can, but they cannot, they don’t have time”. Even in communities where some rehabilitation therapy was available in the hospital, it was not necessarily viewed as helpful in working towards a patient’s discharge. One physician stated “in terms of an active rehabilitation program we are limited in how much we can do”. Similarly another physician remarks “part-time [physio] is no good if you need physio every day”.

Some of the physicians interviewed highlighted the social aspects of a patient’s situation which hampered discharge and for which there was no ready access to social work support in the hospital. One physician stated that the:

difficult situations are where they [patients] don’t have the resources, financially or the family support … it is the social issues the social supports, that’s probably the biggest challenge in this area [discharge planning] and that’s not going to improve and I think we will see it increase as a problem for people just to get the resources that they need.

Another physician similarly suggested “if they [patients] don’t have family support they don’t do well [after discharge], if they are socially isolated they don’t do well, if they don’t have resources like financial resources they don’t do well”. This physician believed this to be
particularly valid for mental health patients. A third physician articulated that their decision to discharge or not to discharge a patient “depends on the social circumstance of the patient”.

The absence of other speciality staff such as dieticians and pharmacists were described as problematic by the physicians when specific patient issues arose. For example, dieticians were most noticeably absent with newly diagnosed diabetic patients. Community or regionally based diabetic clinics compensated for some of this need. At times the lack of in-house pharmacy support resulted in the physician’s medication choices being altered. One physician described “now I am told that I have to change that IV antibiotic on this person because we just ran out, and I think that is bad”.

The physicians interviewed generated several specific themes relating to characteristics and/or realities of their small communities which they believed did not support recently discharged patients. The most clearly articulated was the perceived lack of home nursing services and specifically, the lack of seven day per week home nursing coverage. Home nursing services are not available in any of the communities on weekends or statutory holidays. Only two communities boasted full-time home nursing coverage on weekdays. Varying part-time hours of service were available in the remaining communities. One physician stated “they don’t have enough [home care nursing]. Like I want to discharge somebody but if I discharge them too close to the weekend, well forget that. Because there is no weekend [home nursing] care”.

Community-based rehabilitation services were also seen as lacking and impeding discharge planning and outcomes. One physician articulated:

Not having a physio in the community sometimes causes problems because people with certain types of problems can’t make a trip two hours down the road, to turn around
and come back. It just makes the problem worse just because of the driving.

Another stated “the only physio [available for residents of that community] is for those who can drive to get it”. Only one community surveyed had a private physical therapy clinic which discharged patients could attend.

Four out of the five physicians interviewed described outpatient mental health services in their community as limited or non-existent. One physician remarked that “we have so-so counselling here. They go through counsellors like…”, alluding to a high turnover of counselling staff. This physician elaborated and said “the counsellors we have do everything, so they are not good at anything. They are just like me, I’m not great at much, or anything. I’m a generalist”. Another physician similarly noted that at their local counselling agency:

there is somebody who does mental health counselling but they are not specifically trained in mental health. A lot of the counsellors that we have had here do mental health counselling have done other counselling. We had an alcohol and drug counsellor here, but they like to rotate through mental health and we have a family counsellor who may decide to rotate through mental health but that is not their speciality.

Other supports for mental health patients were also identified as not being in place in the community. One physician described that at times home care nurses administered injection medication to mental health patients but he/she notes “they are not trained to really do that”. Social services were also noted to be lacking for mental health patients. “There is no housing support for them, there is no financing for that and there are a lot of other mental
health needs, supports that in bigger centres are available for patients which we don’t have”.

Provincial social services were viewed by one physician as:

if we could get social services to have the capacity to, I don’t know it just seems like in the past that when I have approached them about certain things they just say that it is not part of their scope and their skill of activity of work in our town and if that could be a little bit broader too because all of us have basically stopped working together with social services except in the cases of family violence or child abuse because they are very limited in how far they can help us. It just seems like their scope of services in town here doesn’t include anything that is of help to us or our patients.

Each physician interviewed outlined that a lack of long-term or alternate level of care beds in the community hampers discharge planning from the acute care facility. One succinctly noted “having some kind of long term care or intermediate care set up where patients could be taken away from the hospital so the hospital could be just acute care” is a great community need. Another notes “you don’t like to have these people [long-term care patients] in acute care beds for obvious reasons but, we are, at times, limited and we do what we have to do.”. Three of the physicians posed as a possible solution to this situation that the community should have some “type of transition/respite type of beds”. In two of the communities where some respite services were available it was not perceived as adequate. “Well we do have a respite bed at the [long-term care facility], and we do use that but...”. Another physician suggested that ideally in his/her community there would be “an alternative care facility of some kind that was staffed separately [from the hospital].”
A final theme highlighted by some of the physicians, was with regards to patients from First Nations reserves. One hypothesized:

I think there is a lot of boredom on reserve, I think because there is a lot of inconsistencies. I think, I know there is a lot of corruption on reserve. The popular Indian, the popular Aboriginal people who are in with the chief, they get the benefits and those who may need it, there is a lot of waste so there is a lot of social issues inside their boundaries. There is a lot of sexual abuse, a lot of sexual abuse and physical abuse and no one tells on anybody so there is nothing you can do about it.

Another relates:

Substance abuse is a huge issue [on reserves]. I think also there is a reasonable degree of elder abuse too, well not elder abuse necessarily but uh [neglect], well we’ll discharge a guy, he’ll go home with family and a week later he has called an ambulance and he comes in and he hasn’t washed, his clothes are filthy and obviously soaked with urine and obviously there hasn’t been the care.

The physician elaborates “I think there may have been a lot of psychological damage, this guy physically abused his kids and his wife and they’re, they’re just not willing to help him. They come and pick him up and do the minimum”. These community realities do not support discharged people. Physicians identified that the frail elderly, mental health patients and patients living on First Nation reserves were the most difficult to plan discharge for.
Summary of physician themes.

The key informant group composed of physicians generated nineteen themes relating to how discharge planning is accomplished at the rural and small town hospitals where they practice. These themes can be grouped into categories which relate to (1) the physicians’ perception of discharge planning at the local hospital, (2) perceived strengths of the hospital/community at facilitating discharge planning and (3) characteristics of the hospital/community which negatively impact discharge planning. In summary, the physicians indicated a reliance on nursing staff to assess and identify patient needs and to develop and carry out the discharge plan. The physicians noted that the informal relationships which exist in small communities between physicians, nurses, and patients facilitate both the attainment of good patient assessment information and the achievement of suitable discharge plans. The physicians acknowledged that the pressure to discharge patients quickly is not excessive at their small town hospitals as they are not typically full to capacity. Provincial home care nursing and home support services as well as the hospital offering outpatient services were seen as valuable assets for discharge planning. Informal supports were also viewed as important and quite readily available in the small community context. Difficulties in planning for patient discharge were identified as being primarily due to a lack of specialized services at the hospital and in the community. The frail elderly, mental health patients, and patients living on First Nation reserves were believed to pose significant discharge planning challenges.

Themes of the Nursing Key Informant Group

Twenty themes were generated by the nursing key informant group. These themes relate to (1) approach to discharge planning, (2) perceived strengths of the hospital/community at facilitating discharge planning and (3) characteristics of the hospital/community which negatively impact discharge planning. These categories are expanded on below.
1. **Approach to discharge planning.**

The nurses role in discharge planning is described as generally including assessment/interpretation of when a patient was ready to go home, facilitating and coordinating communications within the hospital context, and with the physician, and making referrals to follow-up services. Each of the nurses interviewed identified that some type of structure or formalization existed with regards to discharge planning system at their facility. These formal systems varied in complexity from community to community. In one community, weekly inter-agency discharge conferences or meetings are held to discuss both in hospital patients and out of hospital patients experiencing difficulties. A formal record of these discussions are generated. In another community, formal written policies and procedures regarding discharge planning are in the process of being developed but in the meantime, weekly multidisciplinary rounds are held which contribute to discharge planning. In another community, a discharge instruction/information sheet is completed and given to patients. The nurse from that community said:

> I think having the form, the discharge planning form that must be signed before they leave helps. If you have to fill this thing out you have to think about it. Patients keep one copy and you keep one copy on the chart and if you don’t have it on the chart then the medical records person will come looking for it.

At other facilities discharge planning documentation is completed at the discretion of the nurses and if done, becomes part of the inpatient record.
Despite the existence of some formal structure for discharge planning, descriptions of informal approaches to discharge planning dominated the nurses’ interviews. With regards to internal coordinating and communications functions one nurse describes:

we are very good at like having informal patient conferences, um we have a really good rapport with all of our doctors so and that goes on a lot like, ‘how long do you think...’ or ‘what’s your plans here, what are we going to do with this person’ so that goes on a lot but not on a formal say, rounds or a formal team conference we just do it informally.

This nurse went on to say:

whether it is house keeping, laundry, dietary, everybody, like we call patients by their first names, we know them, we are involved with them, like guaranteed housekeeping will be doing some social interaction with them and a lot of times they’ll come and say, ‘did you know she doesn’t have such and such at home or she needs what ever’ so it is a real team thing here.

In all communities it was suggested by the nurses that because their hospitals were infrequently full, and the push for beds not urgent, as a facility they had the flexibility to keep a patient a few days longer than absolutely medically necessary until it was very clear that they would be able to manage in the community outside of the acute care facility. “We won’t discharge until they are ready to function or they have good family support system to help them do that” Another nurse suggests “we are a little more lax than other places but we know these people, we know where they’re going to, like 20 miles out in the bush, or that they are
going home with an elderly husband or wife”. This flexibility in determining the discharge date was viewed as a significant benefit for patients.

2. **Perceived strengths of the hospital/community at facilitating discharge planning.**

The nurses interviewed were able to identify several strengths of their hospital and community which facilitate discharges and discharge planning for patients from their acute care facilities. The primary theme, as suggested above, relates to the nurses having knowledge and understanding of patients and their home situations as a result of being fellow community members. The relationships between patients and nurses were described as ‘personal’. As one nurse articulated, “staff know the patients, patients know the staff, we know the patient’s neighbour that sort of thing”. Several comments indicate that the determination of when a patient was ready for discharge resulted from “we know these people, we know where they’re going home to” or “we know who has friends or relatives, we know where they live and what not and we will take that into consideration”.

The personal relationships small hospital nurses have with patients also characterizes their relationships with other hospital staff and also with external services/workers. The nurse from one community in referring to community rehabilitation and home nursing services, noted succinctly “we are all in this together”. These collegial relationships are reflected in the informal referral processes frequently used with follow-up resources. One nurse, when asked how that community’s counselling agency became involved with patients simply stated “we just call them up and they come over” or for another service “we leave a message on their machine”. A written referral was not necessary in most instances. Another nurse elaborated on this and said:
communication, is our largest strength I think, and speed. We have very little
documentation. We have only the basic necessity and the rest is done verbally and I
know that goes against the grain of most risk management people but the problem is the
more documentation there is the more people you need to run the program so really it
takes away from the effectiveness of the program, I always believe that you need to
look at the outcome, if you have a happy and satisfied client at the end of it that is all
that you really need and people get too hung up on the paper part.

Another nurse elaborated:

Rules do get bent sometimes and we probably make phone calls that we shouldn’t some
times or we... but people get looked after. They don’t go home and drop dead on us or
lay in bed and suffer for weeks on end, it just doesn’t happen.

The nurses interviewed identified that the absence of a variety of health personnel
effectively limited the number of persons involved with a patient and nursing’s resultant
multiple roles, facilitated holistic, coordinated care and discharge planning. “There’s me” one
nurse articulated, “I know all aspects”. When asked about the communication amongst nurses
with regards to monitoring a patient’s progress towards discharge, one nurse noted that
“because we are so small we can do it, we can keep track” of how a patient is doing. Similarly,
another nurse noted that because of the facility’s small size “you know everyone” and
thus information sharing between nurses was not perceived as difficult.

The nurses at the rural and small town hospitals also saw supporting recently
discharged patients as part of the hospital’s role. As such the hospital itself had become a
community resource. Supports regularly offered to discharged patients included providing information over the telephone or directing patients to return to the hospital for direct nursing services. For example one nurse said, “we tell them [discharged patients] that they can come up here anytime or phone us, I often tell, particularly maternity patients, call us, we’re here 24 hours a day.” At each community the nurse interviewed noted that discharged patients are frequently asked to come back to the hospital for services such as wound dressings and intravenous medications as part of their discharge plan. The nurses surveyed also indicated that the hospital would lend equipment to patients if necessary for them to manage at home. Walkers, wheelchairs, glucometers and such were provided on the short term if acquiring these items was a barrier to discharge.

The nurses interviewed identified that informal supports were generally readily available in their communities and frequently constituted an important part of discharge plans.

It [the community] is very close knit and we can call and say look, so and so is going home, mind you we ask the patient who can we call and they say what’s his name drops by once in a while so we’ll call and say we’re sending so and so home can you drop in or look in on him over the weekend, that kind of thing happens.

Put slightly differently, “when it is a small town like this you know everyone and you know the connections, like you will know that so and so has a sister or a cousin or their friends with whoever”. From this knowledge informal supports would be mobilized.

Formal community resources were also identified as providing necessary supports for recently discharged patients. The provincial home nursing program was consistently identified by the hospital nurses as the service most frequently utilized. Other home support services
such as personal care and house cleaning were accessed from the provincial continuing care program, through home care nursing personnel. In three of the communities, home nursing personnel were also designated as long-term care assessors. This combination of duties was perceived positively. "As for the long-term care assessing and the home care nursing, they double so much in the clientele they are seeing it just kind of flows naturally and helps them to do their assessment". In another community, "having the home care nurse position combined with home support and public health means that she can look at all of these areas and set up appropriate services all in one visit".

Several other formal community resources were identified as being useful for supporting recently discharged patients but which ones were specifically utilized depended on the circumstance of the person being discharged. Public health nursing was generally viewed as a key follow-up service for maternity patients. Other services identified included Meals-on-Wheels service, community counselling services including alcohol and drug counselling, Red Cross Medical Equipment Loan service, Lifeline, the RCMP and First Nation health services. The nurses interviewed relayed that overall they felt that "we try to get people out as early as we can. I think we do pretty good. I do, I think we try really hard". Another stated "as far as the physical problems I think we do fairly well" and yet another "we do pretty good [discharge planning] considering the resources we have".

3. Characteristics of the hospital/community which negatively impact discharge planning.

Although overall it was believed by the rural and small town hospital nurses interviewed that discharge planning was essentially quite well done at their facilities, several themes suggest possible impediments to discharge planning. The absence of rehabilitation staff was described as a detriment, particularly in cases where mobility was jeopardized. One nurse stated "we had this stroke patient here not long ago and it took a long time to get him/her
into Rehab [rehabilitation unit at the regional hospital]. It took probably two months”. This person remained in hospital for that time as it was not possible for them to manage independently at home. It was also suggested that at times the attitudes or beliefs of the nursing staff could hinder discharge planning. One nurse relates, “our attitudes, sometimes we feel personally that the person isn’t ready to go so we’ll let them stay a while. It is the wants of the nurses or the patient that is holding them back”. Another nurse referring specifically to palliative patients describes that “there are different opinions about [palliative care]…, some people [staff] think that people should not be in the hospital to die and there are others who think that people should have a choice”. In these circumstances whether discharge planning is actively pursued depends on the personal beliefs of the nurse involved.

The nurses also noted that when they were consumed with acute nursing duties, discharge planning activities, at times, would not get completed. One nurse stated:

I would say that it [discharge planning] is a fairly big priority but I would say that it is not always done as well as we would like to because of time constraints because everyday can be different and like yesterday was very busy and you don’t maybe get it done as good as you want.

In a similar vein but with respect to completing rehabilitation exercises with a patient in order to ready them for discharge, a nurse comments “we do our best, but for things other than direct nursing care, they don’t always get done if we’re busy”.

Each nurse interviewed identified several community characteristics which they perceived as impeding discharge planning and negatively impacting subsequent patient outcomes. Not all patients encountered had well developed, supportive informal networks.
Some were very isolated, with few or no connections and others had networks which did not act in ways which supported at home success. One nurse relates:

> there are lots of cases where we will keep people 2, 3, 4, 5 days longer than they would be anywhere else because you can’t send them home because there is no support …
>
> there was a lady from [place name] who had a wood stove, nobody to help. The house was getting cold, so she stayed 2 or 3 days until family showed up back at home to help out and that happens.

A different slant to this that was reiterated in a majority of the communities involved patients who refused to leave the hospital or families who refused to take the patient out of the hospital although the patient had been discharged or was near discharge. Patients who refused to leave at times were described as “they come here for a rest, it’s quiet, they don’t have to decide what’s for supper” or similarly “they use us like a spa”. In other instances it was described that “emotionally they [the patient] can’t do it”. They are unable to manage at home. Families who were reluctant or refused to take their family member home were characterized by the nurses as either not caring (“some families just don’t care”) or not able, “they don’t think they can manage [the care] but there is no reason why not”.

A variety of formal services were identified as lacking by the nurses, with each articulating their own community’s needs. Recurrent themes included a lack or non-existence of long-term care or alternate level of care beds in the community; inadequate home care and public health nursing services i.e. not available on weekends and only within a short radius of the town; inadequate home support services such as homemaker help not being available to all patients i.e. in more distant and isolated areas; a lack of, or non-existence of mental health
services; a lack or non-existence of rehabilitation options in the community; and poor public transportation services. It was noted that facilitating the discharge of First Nations patients to reserves is sometimes difficult as some reserves offer very few services for patients while others offer more. Provincial home nursing services based in two of the communities were being extended to include providing service on reserve in an attempt to address this issue. In one community this extension included the provision of home support services such as homemakers on a First Nation reserve. It was the opinion of the nurses interviewed that if the above services were available or enhanced in their communities, discharge planning for patients at their facilities would be somewhat simpler. As it exists, “patients with poor family support”, the frail elderly, mental health patients, palliative patients and patients living on First Nation reserves were identified as most challenging to plan discharge for.

**Summary of the nursing themes.**

Twenty individual themes were presented by the nursing key informant group. These themes are grouped into categories relating to (1) approach to discharge planning, (2) perceived strengths of the hospital/community at facilitating discharge planning and (3) characteristics of the hospital/community which negatively impact discharge planning. In summary, the nurses identified that their dominant role in discharge planning from rural and small town hospitals included conducting assessments, ascertaining when a patient was able to be discharged, coordinating and facilitating communication and completing referrals. All of these activities were believed to be enhanced, or made easier because of the personal relationships between patients, nurses, and physicians. Formal discharge planning systems were also seen to provide benefits. The hospital providing advice and services to already discharged patients was viewed to be a significant support for these patients. Provincial home care nursing and home support services were also viewed as significant supports. A lack of
rehabilitation staff at the hospital and in the community and limited other formal supports were identified as primary barriers to adequate discharge planning. Patients with “poor family support”, the frail elderly, mental health patients, palliative patients, and patients living on First Nation reserves were identified as posing the most challenging discharge planning issues.

Overall the nurses perceived that good discharge planning was accomplished at their facilities, despite the lack of formal support services available in their small communities.

**Themes of the Former Patient Key Informant Group**

Thirteen themes emerged from the data collected from the former patients of the small community hospitals. Themes were grouped into three general categories. These relate to (1) personal/family influences on the discharge plan, (2) progression towards discharge and the discharge plan and (3) suggestions for improving discharge planning. Specifics of these categories are detailed below.

1. **Personal/family influences on the discharge plan.**

   Each patient in some way alluded to their placing a high degree of importance on being personally independent. Comments included “I’m old, but I’m tough”, “I like being home” and “I like being on my own”. Each patient indicated that their family and friends would assist them in whatever way necessary in order for them to maintain a maximum level of independence. Family and friendship support took many forms and depended on the type of support the patient needed but generally fell into three types. First, practical support such as staying with the patient or as noted earlier having the patient stay with them, ensuring that meals were prepared, housecleaning and laundry done, banking and other errands completed, feeding pets, and providing transportation to and attending appointments with the patient. One patient who lives a few miles from town and who does not drive highlighted this type of support. When asked if he/she had any concerns about not being able to get into town if
needed, the patient adamantly stated that friends/neighbours provided transportation and jokingly stated “there’s my landlord and if I didn’t reach him when I needed someone and just sloughed it off, he’d break my neck”.

A second type of support provided by family and friends was of a financial nature. This included purchasing or otherwise acquiring necessary equipment for the patient. For example, one patient noted that his/her family were going to buy for them “a good walker, one of those ones with wheels and a little seat” as a Christmas present and another noted that a friend had given him/her a glucometer to use until he/she was able to acquire one.

A third type of support offered by families and/or friends was described as emotional and/or social support. Visiting and spending time with the patient is included in this classification and was repeatedly described as an important aspect of care and recovery. Three out of the five patients interviewed had the experience of being transferred from the larger regional hospital, some distance from their home, to their small community hospital prior to discharge and all were very pleased that this was done because it facilitated family and friends visiting the patient while still in hospital. One patient summed up his/her reliance on family for support after discharge by saying “if I didn’t have children, I don’t know what I would have done”.

2. Progressing toward discharge and the discharge plan.

Each patient interviewed indicated that their discharge date was determined by their medical state and whether or not they would be able to ‘manage’ at home. One patient recalled that the hospital staff started talking about and planning for his/her eventual discharge:

Shortly after I got there as I remember it. Yes, shortly after I got there they had me up on the walker and they said ‘you can’t go home until you can walk’ and that sort of
thing so they were preparing even then for the day that I could go home and finally the
day came when the doctor said that there was no medical reason to keep you any
longer, you can practice the walking at home.

Two patients noted that they had wanted to go home earlier than they had, but in reflecting,
each believed that "it was for my own benefit" that they had stayed. One elaborated "I
couldn't have been discharged home by myself, I would never have managed".

The care received by the patients at the small community hospitals was in each instance
described very positively. Comments such as "the nurses were a 100%, the doctors were a
100%, the cooking was 100%" or "I had excellent care by the nurses when I was in" abound.
One patient whose needs were primarily rehabilitative noted however that "the nurses are great
they try to do everything, but they are not specialized". This patient believed that if
rehabilitation therapy had been available at his/her small community hospital he/she would
have been able to return home sooner and that perhaps his/her overall recovery would have
been better.

The patients interviewed described that their primary role in discharge planning was to
work towards getting "better", meaning stronger and more mobile. One patient described that
he/she engaged in self-talk such as "I've got to take charge". Formal discharge supports that
were organized were done so by the nurses and doctors with what appears to be little
consultation with the patient. One patient who had been receiving home maker support prior to
hospitalization noted that on discharge the frequency and duration of his/her home support was
increased but this had not been arranged at her request. Rather, this had been arranged
between a daughter-in-law and the long-term care assessor. The patient in this instance queried
why the family member he/she actually lived with had not been consulted.
Three of the patients interviewed indicated a sense of powerlessness with regards to being readied for discharge and plans made on their behalf. One patient reported that when he/she was told that they were considered ready for discharge by the hospital staff “I thought, there is really nothing you can do, you pretty well have to come home’. Another patient with mobility concerns admitted that he/she had some fears about how to physically get into the house but this was not an issue addressed by the hospital staff.

Not all of the patients however were distressed by plans being made without them. Two patients commented that they were aware at the time of discharge that ‘someone’ would be checking on them at home, but they did not know who or from what program that person originated. In both cases it was home nursing services that were arranged. Not knowing who this person was prior to having them show up at their home was not disturbing to these patients as they had confidence that, if the hospital had set it up for them, it would be beneficial.

A majority of the patients interviewed expressed their belief that information was not adequately shared with them or with their families by the health care workers at the time of discharge. This caused distress and resulted again in feelings of powerlessness. Two patients indicated that friends or family “had to pull information off the Internet” so that they knew what was beneficial for them considering their diagnosis. A daughter who sat in on one of the interviews shared:

they didn’t say anything about what to watch for, or pay attention to this or that, or come back if this happens, they just said ‘go home’. That’s what frustrated the rest of the family, it was up to us and mother to decide if she was well, and we don’t know. We even asked a couple of people and they hummed and hawed and said well if you don’t feel good. Well she didn’t feel good and they sent her home anyway.
Another patient noted that although neither the hospital nurses nor their doctor had explained what to do or watch for at home, his/her family “seem to know what to do”. One of the former patients suggested that the sense of powerlessness which he/she felt extended to the health personnel at the small community hospital.

There is no physio in [community name] and I had to wait weeks to get into Prince George and a bed never came up so I went to [family member] in Prince so that I could have outpatient [rehabilitation] therapy. The doctor and the nurses, we were all frustrated. PGRH rehab said they could not help because they hadn’t assessed me.

One patient provided an example of good information sharing by the local hospital. As a newly diagnosed diabetic, this patient and a family member were taught about a diabetic diet and how to monitor his/her blood glucose levels with a glucometer. Levels were to be recorded by the patient/family and reviewed with the family physician the week following discharge.

All of the patients interviewed described that follow-up with and by their family physician and/or specialist physician was a very important aspect of their discharge plan. It was seen as important for ensuring their physical well-being and also psychologically in that such follow-up provided reassurance. One patient described fondly “Dr. [family doctor] takes good care of me. He phones me up at home if anything is wrong with my blood work or whatever”.

3. **Suggestions for discharge planning.**

As indicated previously, the former patients interviewed for the purposes of this research were overall very complementary of the care and discharge planning that they
received at their local small community hospital. A few specific suggestions were made which are worth highlighting. One family member described that although they were provided with a list of home adaptation equipment by the hospital prior to discharge, it did not contain all equipment which would have been helpful. As a result the family had to make a second trip to the Red Cross Medical Equipment Loan service which was located in another town. It would have been preferred to have only made one trip. One patient suggested:

I think it would be a good idea for the nurses to ask [about someone’s home situation] because nine times out of ten the doctors are usually in a hurry and when they do rounds they don’t have time to talk and explain things to you, like your medication and when to come back and see them. I think the nurses should maybe talk to patients before they are discharged and see if they have help and where they can get it if they need it. Or maybe a social worker”.

A third suggested with reference to the non-existence of rehabilitation services in his/her hospital and community, “it’s part of health care. We should be able to get it. Why can’t they be more creative” in the ways in which such specialized services might be delivered from the regional centre. Coming for an assessment and a list of exercises once per week but returning to the small community hospital in between was posed as a possible option. Video-conferencing in these instances was also thought to be an option worth exploring. The remaining patients stated that there was nothing that they would change in terms of the discharge process they went through at their small community hospital.
Summary of the former patient themes.

As noted in the introduction to this chapter, the themes presented by the patient subgroup were unique and reflected their perspective as a consumer of health care service. Thirteen individual themes were generated which were grouped into categories relating to (1) personal/family influences on the discharge plan, (2) progression towards discharge and the discharge plan and (3) suggestions for improving discharge planning. In summary, the patient themes indicated that self reliance was an important attribute patients held for themselves and their informal support networks acted in ways to support independence. The former patients identified that their primary role in discharge planning was to focus on getting stronger or better while in the hospital. The patients felt that their medical state and ability to manage at home dictated their discharge date from hospital. Follow-up services were in some instances arranged without consultation with the patient and this caused a sense of powerlessness as did receiving what was perceived to be a lack of information at discharge. The former patients were overall very complimentary of the care received from the nurses while they were in hospital. They indicated their belief that the nurses helped prepare them for discharge but noted that the nurses were not specialists in areas which they sometimes required. Follow-up with the family and/or specialist physician was identified by patients as being perhaps the most important post discharge support.

Comparison of Themes Across Key Informant Groups

As themes emerged within each key informant group, it became apparent that a mutually exclusive grouping could be accomplished based on themes which were perceived to have a positive influence on effective and efficient discharge planning and discharge outcomes or those which were perceived to have a negative impact on discharge planning and outcomes. Presented in Table 1 are themes across the key informant groups which were perceived as
positively influencing discharge planning and discharge outcomes. Which key informant
group(s) supported the theme is identified in the table.

Table 1

*Perceived Positive Influences on Discharge Planning and Discharge Outcomes*

<table>
<thead>
<tr>
<th>Perceived Positive Influences</th>
<th>Physicians</th>
<th>Nurses</th>
<th>Patients</th>
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</thead>
<tbody>
<tr>
<td>Personal Relationships</td>
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<tr>
<td>Hospital as Resource</td>
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<tr>
<td>Public Health Services</td>
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<tr>
<td>Counseling Services</td>
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<tr>
<td>Informal Supports</td>
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<tr>
<td>Patient Value of Independence</td>
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<tr>
<td>Generalist Nursing Role</td>
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<tr>
<td>Physician Follow-Up</td>
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</table>

Table 2 displays themes perceived to negatively influence discharge planning and
discharge outcomes. Again which group identified with the theme is indicated. Further
analysis follows the table.

Table 2.

*Perceived Negative Influences on Discharge Planning and Discharge Outcomes*

<table>
<thead>
<tr>
<th>Perceived Negative Influences</th>
<th>Physicians</th>
<th>Nurses</th>
<th>Patients</th>
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</thead>
<tbody>
<tr>
<td>Lack of Home Nursing Support</td>
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<tr>
<td>Lack of Community Mental Health Support</td>
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<tr>
<td>Lack of Public Health</td>
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<tr>
<td>Limited Informal Supports</td>
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<tr>
<td>Distance</td>
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<td></td>
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<tr>
<td>Patient Costs to Travel away</td>
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<tr>
<td>CNBC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of Information Sharing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Attitude and time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Norms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of LTC/ALC beds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Informal Supports</td>
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</tbody>
</table>

<table>
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<td>Other Informal Supports</td>
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</table>
Comparison of themes identified as positively influencing discharge planning and discharge outcomes.

As shown in Table 1 eleven themes were generated across the key informant groups which were believed by participants to be supportive of discharge planning and discharge outcomes. Five of these themes were present in all three key informant groups. These areas of consensus are (1) ‘personal’ relationships exist between physicians, nurses and patients which facilitate the development of discharge plans. (2) The hospital fills an active role in supporting discharged patients (i.e. offering advice, dressing changes, loaning equipment), (3) home care nursing and home support services provide valuable support. (4) Other formal support services (i.e. Red Cross Medical Equipment Loan Service, Lifeline, Meals-on-Wheels) and (5) informal supports (i.e. family, friends, neighbours) are very important in supporting a recently discharged patient.

Of the eleven positive themes identified, three were jointly identified by physicians and nurses but not by patients. These joint areas were with regards to (1) the informality and flexibility of the discharge planning process utilized in the small community hospitals. Within this are sub-themes of ease of communication, no formal protocols to follow and minimal pressure to discharge patients due to bed pressures. (2) Public health nursing follow-up is important particularly for maternity patients and (3) the availability of community counselling services.

It is suspected that patients did not identify with the first of these themes because they were not aware that the process was either formal or informal. This category of themes relates more to the internal hospital system to which patients are not typically privy. It is also possible that as residents of the small communities, they are accustomed to informal and flexible approaches to problem solving and thus such an approach to discharge planning did not stand
out to them as out of the ordinary and thus not worth mentioning. Without the experience of having been involved in a formal discharge planning process it would be difficult to identify the one used at the small community hospital as informal.

With regards to the latter two themes identified by physicians and nurses but not patients, it is suspected that this occurred because the two identified formal supports, public health nursing and community counselling services were not appropriate or applicable to meeting any of the interviewed patients particular needs. If different patient participation criteria had been set for the study, for example patients in their 30’s, results may have been different.

Two of the eleven themes positively impacting discharge/discharge planning were related to by physicians and patients, but not nurses. These themes were (1) patient attitude/value of independence and (2) the importance of follow-up with the family physician and/or specialist physician.

It is not readily evident why nursing personnel did not identify these themes and explanations are speculative. However, it is interesting to note that one physician stated that the “nurses, their jobs are to disempower them [patients]”. This physician also noted that health care workers got “ticked off” when a patient “disrupted our routine. We need that routine”. In this light, independence exhibited by patients could be perceived as behaving outside the norms of accepted patient behaviour. Two other comments from the interview transcripts may support this. A patient stated “I thought that I was going to go to the bathroom and of course I didn’t know how to get moving, and I got this foot down and this foot got stuck and I ended up sitting on the floor, four nurses gathered around me looking most irate”. One nurse stated:
"we were having problems with control and there is the two RNs and if there is an emergency in emerg. they are over there so physically they are away from the acute care so they [psychiatric patients] were controlling things. Like, trying to be helpful, but it just wasn’t working.

The issue of control/loss of control for nursing personnel may be worthy of additional research attention, but it is outside the scope of this current analysis.

With regards to the second theme relating to the importance of physician follow-up it is plausible that the nurses interviewed simply viewed physician follow-up as standard medical practice versus being a formal discharge support and thus it was not considered specifically as an aspect of the discharge plan.

One theme was identified by both patients and nurses as being supportive of effective discharge planning but was not identified by physicians. This was the generalist role assumed by these small hospital nurses. The lack of specialist staff such as rehabilitation therapists at these hospitals meant that the nurses assumed some of the roles typically assigned to these specialists such as teaching/assisting a patient to mobilize after orthopaedic surgery. Patients tended to view this as the nurses providing good care and nurses felt that such activities provided them with a holistic view of how the patient was doing. Physicians conversely viewed the nurses assuming these functions as a necessary reality but did not necessarily believe that it lead to optimum patient outcomes.

Comparison of themes identified as negatively influencing discharge planning and discharge outcomes.

Thirteen themes considered to negatively impact discharge planning and discharge outcomes emerged across the three key informant groups. Six of these refer to a lack of
Discharge Planning at Rural and Small Town Hospitals

specific formal services. Three themes were identified by all three of the key informant
groups. These related to (1) a lack of specialized staff at the hospital, (2) a lack of community
rehabilitation services and (3) distance factors. Distance factors refer to both having to travel
away from the home community to access necessary goods and services for example physical
therapy, medical equipment loan services or physician follow-up and also to the fact that some
services which may be available in the small community townsite are not available in outlying
areas.

Of the thirteen themes perceived as negatively influencing discharge planning identified by
both the physician and nurse key informant groups, but not by the recently discharged patients.
These themes were:

(1) Limited informal supports. The informal support system includes support provided by
family, friends, neighbours, voluntary groups etc. A small or non-existent support system or
ones that did not engage in activities that supported the person being out of hospital are
described in this theme. Included also are families who “refuse” to take a person out of
hospital. It is suspected in this research that the patients did not view this a problem area
because each patient interviewed described having a well developed and supportive informal
network. Again, patients were asked to speak to their own personal experiences.

(2) Lack of Home Nursing and/or provincial Home Support services. The non-availability of
seven day per week home nursing services was a theme highlighted by physicians and nurses.
Home nursing and home support services are grouped together as home nursing was the direct
conduit to instituting home support services in all of the communities regardless of whether the
home care nurses were formally designated as long-term care (LTC) assessors. Repeatedly it
was noted that patients would be kept in hospital longer than necessary until home care nursing
was “able to pick them up”. Patients interviewed likely did not identify a lack of home care
nursing and/or home support services because the two that required such service had it arranged for them and neither of these required daily attention and thus would not have noticed that daily service was not available. Two patients were not aware that such services were available to them on physician recommendation and one did not require such services.

(3) Lack of specialized mental health services. It was described by the physicians and nurses that mental health patients had few or non-specialized resources to support their specific needs in hospital or out. Again it is suspected that patients did not identify this as an area not supporting discharge because it was not applicable to them. None of the patients interviewed had been admitted to the hospital with a primary mental health diagnosis.

(4) Lack of community social services. Poor housing, limited financial resources, limited support for victims of violence/abuse were cited as examples of difficulties affecting patients for which social services were not readily available in the communities. It was also suggested that inflexible regulations such as requiring clients/patients to go to services versus these services having an outreach component, reduces the accessibility and utility of some of the existing programs. This theme was likely not presented by the patients interviewed because their needs did not necessarily fall into this realm and if they did, i.e. limited financial resources, their informal support network addressed these needs. It is also possible that the former patients interviewed for the purposes of this interview were reluctant to divulge such personal information to the researcher.

(5) Lack of long term care or alternate level of care beds. At each acute care facility it was noted by both physicians and nurses that consistently some of the acute care beds are occupied by persons not requiring acute care services. These persons included those awaiting a LTC facility bed, those receiving palliative care, those needing rehabilitation services and those receiving what was termed, “supportive convalescent care”. The patients interviewed by
research design, were all discharged home and thus at the time of interview did not fit into any of the circumstances described. It should be noted however that at least two of the patient participants had remained in the acute care hospital for an extended period because of mobility deficits which made managing at home impossible. A portion of their stay in hospital could arguably be classed as non-acute. These patients did not see their staying in the hospital as a reflection of poor discharge planning but rather as the only viable option present at that time.

(6) Community norms. This theme was made in particular reference to First Nation reserve communities. Physicians and nurses noted that reserve issues such as rampant substance abuse, unemployment and violence combined with a lack of formal services did not provide a supportive context for patients recently discharged from hospital. None of the patients identified this as a theme because none originated from that community context. One was of First Nations descent, but did not live on reserve.

No themes were jointly identified by physicians and patients exclusive of nurses. Of the four remaining themes characterized as negatively impacting discharge planning and discharge outcomes, two were identified by only the nursing group, and two were identified by the former patients. The themes exclusively identified by nurses as negative influences on discharge planning were first, a perceived lack of, or uncoordinated follow-up of maternity patients. Nurses described that like home care nursing services, public health nursing which typically does home visits to recent maternity patients and their newborns is not available seven days per week and thus visits sometimes do not occur for several days after a discharge. It was also noted that a large proportion of maternity patients deliver their baby in other communities where more neo-natal and/or obstetrical services are available. It was suspected by the nurses interviewed that public health did not receive referrals on all of these patients and
thus follow-up was not provided. It is not known if this is truly the case, but it was a concern of the nurses interviewed.

The second theme identified exclusively by nurses related to nursing attitudes and time constraints. Within this theme it was noted that a nurse may personally think/want a patient to remain in hospital longer and therefore they do. It was also described that if nurses are busy with acute nursing care, discharge planning activities may not get done. At such times discharge planning is not considered to be the priority.

Patients alone identified the following two themes. First, the patients perceived a lack of information sharing/consultation between health care providers and themselves. Not receiving what was perceived to be adequate information regarding their health condition and/or follow-up services was a theme presented by patients and/or family members participating in this research. This included not knowing basic information such as what or what not to eat, what symptoms to be aware of, physical activity restrictions or exercise recommendations. It also included not being informed or consulted about follow-up support service options available or arranged. This lack of information sharing could indicate that discharge plans were made for patients, instead of with patients. Such an approach by health care workers could be based on a belief that they know what is best for patients. Inherent in such a belief is a power imbalance. Such practice could also reflect expediency. It takes longer to meet with and consult a patient and their informal support network than to unilaterally take action. It is also possible that information was shared but not retained by the patient. This would not be unexpected considering the consciousness altering medications, particularly analgesics, which patients often take while in the hospital setting. The literature on discharge planning particularly that written from a social work perspective highlights the importance of engaging with patients to
develop mutually agreed upon plans. Such an approach is believed to more successfully ensure that patient needs are met and satisfaction increased.

The second theme described exclusively by patients related to costs incurred by them and their informal networks to access needed services in other communities. These costs included the financial costs associated with travelling, out of town accommodations, but also the personal costs related to the inconvenience and expense incurred by family/friends who assisted with accessing these services. This author would add as a financial cost ambulance expense. It is suspected that ambulance costs were not highlighted by the patients interviewed because none had yet received bills for their recent use of the service. Invoices or bills are generated by the BC Ambulance service some months after the service is delivered. In British Columbia patients are responsible for arranging payment of ambulance bills except in cases where patients are transported from one facility to another and returned to the original facility within 24 hours. As a per kilometre rate is charged, in some instances the bill can be large.
Conclusion

The purpose of this qualitative research was to shed light on the question “how is discharge planning accomplished at rural and small town hospitals within the Northern Interior Health Region of British Columbia?” and in doing so to contribute to the knowledge base regarding the realities and functioning of such small town hospitals. This goal has been accomplished.

Inherent in the research question was an assumption that context, (i.e. rural versus urban hospital location), impacts on discharge planning processes and practices. This assumption was based on the fact that the urban based literature on discharge planning describes as necessary many processes, practices and personnel which the researcher knew from experience simply did not exist at the rurally located, small town hospitals. For example, the literature suggests that a multi-disciplinary team is necessary for adequate discharge planning to be accomplished. It was known prior to embarking on this research that none of the hospitals surveyed had what could be referred to as multi-disciplinary staffing. It is also suggested in the literature that formal policies, procedures and dedicated personnel are needed for quality control of discharge planning at a facility. It was not known for sure, but it was suspected by this researcher, that limited structure was in place with regards to discharge planning at the small community hospitals. Subsequent results support the assumption. The discharge planning procedures and practices in place at the rural and small town hospitals studied can be characterized as more informal than formal. This is not to suggest that formality or structure is unnecessary at larger urban based hospitals, but rather it is suggested that it is not entirely necessary at small rurally located hospitals.
The results of this study suggest that the rural and small town hospital context does both support and hinder discharge planning and discharge outcomes for persons using these facilities. Much of the positive influence on discharge planning stems from the personal relationships between patients, nurses and physicians. It is suggested that these relationships enhance holistic assessment of client need, and enable easier communication between partners in the discharge plan. A lack of specialized, in-hospital services, particularly rehabilitation services were identified as barriers to efficient and effective discharges. Limited, inappropriate or inaccessible community based services were also identified as impeding discharge planning and discharge outcomes from these rural and small town facilities. The hospitals compensated for these barriers at times, by keeping patients for extended admissions if discharge was not feasible. This is possible because typically the hospitals are not full to capacity and the “pressure” on beds not substantial. The hospitals surveyed routinely act as a direct resource or support for discharged patients. Often former patients return for dressing changes, wound assessments, to borrow equipment or obtain medications. It is suggested that this expanded role of the small community hospital beyond providing only acute inpatient care, helps to ensure that residents of rural and small town areas have access to health care services and supplies which they require. For patients unable to access the hospital for follow-up services and particularly for those who live outside formal service delivery areas, obtaining needed services was not always possible and hospital admissions were extended. In urban centres, follow-up services are not routinely offered to discharged patients by the acute care facility but rather through home or community based service providers.

Overall, the results of this study suggest that, given the circumstance of limited resources both within the hospital and within the community, discharge planning is reasonably well accomplished. An intrinsic goal of this research was to obtain and present information
which could be used to enhance the discharge experiences of rural and small town residents utilizing their local community hospital. Based on the results of this study, three thoughts are offered to this end. First, formal community-based supports such as home care nursing, mental health services, and social services require augmentation and co-ordination. Existing services and service delivery models are not always appropriate or accessible for patients requiring these services. Social services particularly must come to view their role as not distinct from, but rather a component of health care delivery. The profession of social work is already concerned with the social determinants of health e.g. poverty, homelessness, low education levels violence etc. but infrequently are these issues conceptualized in terms of health status and health care provision. From the author’s experience, an ‘us’ and ‘them’ mentality exists between social work and medical health professionals. This is unfortunate. Quality service provision requires a “we” approach. Schools of social work can work to foster such a shift in orientation by establishing course work on the interface between the social work profession, the social determinants of health, and health care provision. Advanced practice skills for social workers in the health field could also be taught. Equipped with such knowledge, social workers would be able to work more cohesively with other health professions to enhance the health outcomes of those in need.

The second thought I offer toward enhancing discharge experiences of rural peoples, is with regards to making specialist resources, particularly rehabilitation therapy, more accessible to rural hospitals and rural residents. Travelling clinics, and the use of technology such as videoconferenceing were suggestions provided by participants as potential solutions in this area. The personal and financial costs incurred by patients who must travel to other, typically larger communities to access services and supplies was described as burdensome by patients.
The third suggestion I make to enhance discharge experiences for persons using rural and small town hospitals, based on the results of this study, is directed to health care providers. Patients from rural and small town areas value their independence. As such, they need to be fully included in planning for their discharge. This requires that information be shared and support options discussed. Such an approach would help to reduce the feelings of powerlessness described by the patients in this study.

It is anticipated that the health care system in British Columbia will undergo substantial redesign in the near future. It is hoped that the information generated by this research and contained in this thesis will be of interest to those involved in the redesign process. The implementation of the above noted ideas for enhancing health care service to the residents of rural and small town British Columbia will require both macro-level systemic changes as well as changes to local service delivery modalities. Changes made in the formal health/social care delivery system must not detract from informal processes and supports which currently contribute substantially to the support of discharged patients in rural and small town areas. Changes rather, should aim to enhance the informal networks ability to provide such care. How this can best be accomplished is a question which must be referred back to and answered by the communities themselves.

Suggestions for Future Research

This research represents an initial attempt at formally exploring discharge planning as practised at rural and small town hospitals. Although an adequate sample size was utilized (n=5 in each key informant group as well as 5 communities/hospitals explored), results are not necessarily generalizable beyond those directly sampled. Tesch (1990) states “one study alone will not provide the whole picture” (p. 305) and as this is an original piece of research, it cannot be assumed to represent all other rural and small town hospitals and locations. Guba
and Lincoln (1989) also note that generalizability requires random sampling techniques which were not employed in this research. These authors further suggest that the scholarly worlds' preoccupation with generalizability “has led to what some have called ‘context-stripping’... [and] the motivation for such context-stripping is in any event mistaken, in that generalizations are not possible [italics in text]” (p. 36). Context is of utmost importance in this study on discharge planning. Rather than generalizability, Guba and Lincoln (1989) suggest that in qualitative research the concept of ‘transferability’ be used. Transferability refers to “the degree of similarity between sending and referring contexts” (p. 241). The major technique for establishing transferability is believed to be “thick description” (p. 241). I have included in this thesis what I believe to be thick description of the sampling, data collection, and data analysis methods employed. Tesch (1990) suggests however that “in qualitative research no two scholars produce the same result, even if they are faced with exactly the same task” (p. 304). This non-replicability is viewed as acceptable and even desirable “as qualitative descriptions accumulate, they will make it possible for us to gradually ‘recognize’ the phenomenon” (p. 305). As such, it would be worthwhile to have this research repeated in different communities, in different jurisdictions i.e. different health regions/different provinces and results compared and compiled. Alternate research designs could be considered such as interviewing a physician and a nurse about their specific approach to discharge planning with one particular patient who could also be interviewed. This approach may enhance comparability of results across the three perspectives. Focusing on difficult to discharge patients such as those with few informal supports would likely generate different information than what was found in this research and may assist in the development of strategies to aide in planning for this group. An observational research design of following a case through the
hospital and into the community could also prove enlightening. The emerging field of rural health research would be complemented by such future endeavours.
References


Tennier, L. (1997). Discharge planning: An examination of the perceptions and
recommendations for improved discharge planning at the Montreal General Hospital. *Social Work in Health Care*, 26(1), 41-60.


Appendix A

Map of the Northern Interior Health Region of British Columbia
Dear Hospital Administrator:

Rural health and health care delivery is currently an area of heightened interest. Increasingly it is acknowledged that urban-based service delivery models have limited relevance in the rural environment. I request your facility’s participation in an exploratory research project designed to further understanding in this area.

The proposed research will examine how discharge planning occurs at small community hospitals within the NIHR. The methodology involves conducting interviews using a semi-structured interview format with the three key participants involved in discharge planning; the physician, the nurse and the patient. In each of the five small communities of the NIHR hosting acute care facilities it is hoped that one of each type of participant will be interviewed. Both strengths of, and barriers to, successful discharge planning will be explored. It is hoped that the information generated and compiled will be useful for planning purposes in addition to generating knowledge. This research will form the basis of my Master’s of Social Work thesis which I am currently completing at UNBC. The proposed project has received approval by my three member thesis committee at UNBC and it will be submitted for formal UNBC and NIHR ethics review and approval once your support is obtained.

I will contact you in approximately one week to ascertain your interest in having your facility represented in this research. Participation is of course completely voluntary. If you are interested, I will ask for you to provide to me the name of two or more nurses employed at your facility who would volunteer to be interviewed by myself at the location of their choice. I will randomly select one individual to be interviewed. Interviews are anticipated to take approximately one hour and will be audio-taped for later analysis. Audio-tapes and subsequent transcripts will be maintained in a secure location at the researcher’s home for a period of two years and then destroyed. Participant names and locations will be coded so as to be non-identifying in any written documentation arising from this research. My thesis supervisor, Glen Schmidt may require access to original audio-taped/transcribed material as necessary.

If you have any questions regarding this research, please do not hesitate to contact me at 962-2234 or my supervisor Glen Schmidt at UNBC at 960-6519. I can provide to you a copy of the entire research proposal if that would assist in your decision making. Any complaints regarding this research should be directed to the Vice President of Research at UNBC at 960-5820. If your facility participates in the study, I will upon successful defense of my thesis forward to you an executive summary for your information and feedback. Your consideration is appreciated and I look forward to speaking with you next week.

Yours truly,

Sandra Harker
October 22, 2001

Ms. Sandra Harker
Social Worker
Prince George Regional Hospital

Dear Sandra:

Re Study Titled:  How Does Discharge Planning Occur at Small Community Hospitals within the Northern Interior Health Region

Thank you for your attending the meeting of the Research Review Committee on October 16, 2001 where your research application was reviewed.

We are pleased to inform you that your study has been approved with the amendments to pages 3, 4 and to Appendix “C” Letter of Introduction to Patients as presented and submitted at the meeting.

Upon completion of your study we ask that you provide the Committee written notification that the study has concluded and include an anticipated time frame in which you will be available to present your findings.

We wish you every success in your study and look forward to reviewing your findings upon receipt of your final report.

Sincerely yours,

Dr. Jennifer Rice,
Regional Medical Director
Acting Committee Chair
RESEARCH REVIEW COMMITTEE

/bb
MEMORANDUM

To: Sandra Harker
3071 Killarney Drive
Prince George, B.C. V2K 2A8

From: Alex Michalos
Chair, Research Ethics Board

Date: November 2, 2001

Re: Ethics Review 2001.1025.96
How Does Discharge Planning Occur at Small Community Hospitals Within the Nihr of British Columbia

Thank you for submitting the above noted research proposal to the UNBC Research Ethics Board for review. Your proposal has been reviewed and approved and you may now begin your research.

If you have any questions, please feel free to contact me.

Sincerely,

Alex C. Michalos, Chair
Research Ethics Board
Dear Physician:

Rural health and healthcare delivery is currently an area of much interest. Increasingly, it is acknowledged that urban-based service delivery models have limited relevance in the rural environment. I request your participation in an exploratory research project aimed at furthering knowledge in this area. This research will form the basis of my Master’s of Social Work thesis which I am completing through UNBC.

The proposed project has undergone UNBC and NIHR ethics review and approval. Specifically, the research will investigate how discharge planning occurs at small community hospitals within the NIHR. Both strengths and barriers to effective discharge planning are sought. It is hoped that such information will be useful for planning at such hospitals. The research involves interviewing three key participants in the discharge planning process at each of the five small communities hospitals of the NIHR. These participants are a physician, a nurse and a discharged patient. Participation is of course voluntary but due to the ultimate responsibility of physician’s for discharge planning, at least one physician representative from each location is sought. If more than one physician volunteers to participate in a given location, one will be randomly selected for interview. Due to time constraints and busy schedules it is planned for interviews to be less than one half hour in duration and at a time and location of your choice. Interviews will be audio-taped for later analysis. Both the audio-tapes and subsequent transcripts will be maintained in a secure location at the researcher’s home for a period of two years prior to destruction. Participant names and locations will be coded so as to be non-identifying in any written documentation arising from this research. My academic supervisor, Glen Schmidt may have access to original audio-taped/transcribed material as necessary.

If you have any questions regarding this research, please do not hesitate to contact me at 962-2234 or my supervisor Glen Schmidt at UNBC at 960-6519. Any complaints regarding this project can be directed to the Vice President of Research at UNBC at 960-5820. I will contact you in approximately two weeks time to assess your interest in participating in this research project. Your consideration is most appreciated and I look forward to speaking with you.

Yours truly,

Sandra Harker
Dear Patient:

I am a researcher completing studies at the University of Northern British Columbia in the Master’s of Social Work program. I am currently undertaking a research project as part of my studies which looks at discharge planning at small community hospitals in the Northern Interior Health Region. Discharge planning is a term used to describe how patients are made ready for discharge to home by a hospital. In this research I will be interviewing doctors, nurses and recently discharged patients.

I ask that you consider granting me an interview to discuss your experience. Interviews will be audio-taped for later analysis. Both the audio-tapes and subsequent transcripts will be maintained in a secure location at the researcher’s home for a period of two years prior to destruction. Participant names and locations will be coded so as to be non-identifying in any written documentation arising from this research. My academic supervisor, Glen Schmidt may have access to original audio-taped/transcribed material if necessary. This study has been reviewed and granted ethical approval by both the University of Northern British Columbia and the Northern Interior Health Region. It is anticipated that interviews will take approximately one hour and will be scheduled at the time and place of your convenience.

If you are interested in participating in this research project please indicate your name, address and telephone number on the bottom of this letter and return it to your nurse. Only one patient, from those interested, will be chosen for interview from your community. Participation is strictly voluntary and you may withdraw at any time. If you do not wish to participate it will in no way effect your current or future medical treatment. If you have any questions, please do not hesitate to contact me at (250) 962-2234 or my supervisor Glen Schmidt at UNBC at (250)960-6519. Any complaints regarding this research can be directed to the Vice President of Research at UNBC at 960-5820. Your consideration is most appreciated and I look forward to speaking with you.

Yours truly,

Sandra Harker

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Yes, I am interested in participating in the Research project on discharge planning.

Name: ___________________________________________

Address: _________________________________________

Telephone: ______________________________________
Consent for Participation

*Research Question:* How is discharge planning accomplished at rural and small town hospitals within the Northern Interior Health Region of British Columbia?

I, _______________________________ (former patient, nurse or physician) have had the above named research project explained to me by researcher Sandra Harker and hereby give my consent to be interviewed for purposes of participating in the research. I am aware that interviews will be audio-taped and then transcribed using codes so as to not identify me. Tapes and transcripts will be kept by the researcher, in a secure location at the researcher’s home for a period of two years and then destroyed. I am aware that participation is voluntary, includes no remuneration, and that I may withdraw my participation at any time. Results will be made available to me in the form of an executive summary, and the full thesis document will be available at the UNBC library. I (would or would not) like a copy of this Consent for Participation for my records.

Participant
Signature: ____________________________ Date: ____________________________

Researcher: __________________________ Date: ____________________________

Thank-you for your participation.
Appendix H

Physician Interview Guide

1. Demographic/Personal Information
   a) Number of years practicing as a physician in the current community
   b) Number of years as a physician
   c) Have you practiced medicine in other small communities, and at other small hospitals?
   d) How long have you lived in your current community?

2. Hospital Information
   a) How many acute care beds are there at the local hospital?
   b) What types of patients (diagnoses) are most commonly treated by yourself at the hospital?
   c) Does your hospital offer any surgical services? If so, are you involved in these and in what capacity?
   d) Does your hospital employ any allied health professionals (i.e. physio, OT, speech, dietitian, social worker). If so, are they readily available?

3. Discharge Planning
   a) Is discharge a priority within the local hospital? Why or why not?
   b) Describe the discharge process typically engaged in with your patients at the local hospital? Is there a formal/standardized discharge plan/process? When does discharge planning begin? Who is involved? What roles do they play? What do you take into consideration?
c) What kinds of problems arise in the discharge process most often? Provide an example. How are such cases resolved?

d) Do patients ever remain in hospital longer than absolutely medically necessary due to difficulties in discharge planning?

e) What are your thoughts on patients transferred to you and the local hospital from tertiary care centres. Do they pose any unique discharge issues?

f) Based on your experience, what are the barriers to effective and efficient patient discharge at your facility?

g) Based on your experience, what are the strengths of your hospital at facilitating effective and efficient patient discharges?

h) Are there any other comments that you would like to make about the discharge process engaged in by yourself and the staff at the ____________ hospital?
Nursing Interview Guide

1. Demographic/Personal Information
   a) Number of years employed as a nurse at the current hospital ______
   b) Number of years as a nurse ______
   c) Do you have any previous work experience at a small community hospital? If so how much? Where?
   d) How long have you lived in your current community?

2. Hospital Information
   a) How many acute care beds are there at your facility?
   b) What types of patients(illnesses) are most commonly treated at your hospital?
   c) Does your hospital offer any surgical services?
   d) How many RNs are employed at your facility? How many typically work on a day shift and night shift.
   e) Does your hospital employ any allied health professionals (i.e. physio, OT, speech, dietitian, social worker). If so how many hours per week are they available?

3. Discharge Planning
   a) Is discharge a priority within your organization? Why or why not?
   b) Describe the discharge process utilized at your facility? (i.e. is there a formal/standardized discharge plan/process? When does discharge planning begin? Who is involved? What roles do they play? What do you take into consideration?)
   c) Does the hospital follow-up with discharged patients to assess how they are managing?
d) What kinds of problems arise in the discharge process most often? Provide an example. How are such cases resolved?

e) Do patients ever remain in hospital longer than absolutely medically necessary due to difficulties in discharge planning?

f) What are your thoughts on patients transferred to your hospital from tertiary care centres. Do these patients pose unique discharge issues?

g) Based on your experience, what are the barriers to effective and efficient patient discharge at your facility?

h) Based on your experience, what are the strengths of your hospital at facilitating effective and efficient patient discharges?

i) Are there any other comments that you would like to make about the discharge process utilized at ____________ hospital?
Patient Interview Guide

1. Demographic/Personal Information
   a) Name
   b) Age
   c) Sex
   d) Marital Status
   e) Tell me about where you live. (e.g. in town, out of town, house, trailer, regular utilities etc.)
   f) Do you live alone or with other people? If so, with whom?
   g) Do you have any other family living nearby?
   h) Who do you normally call on for support or assistance if you needed it?

2. Hospitalization Experience
   You were recently a patient at __________ hospital.
   a) Why were you admitted?
   b) How long were you in hospital?
   c) Were you transferred to or from any other hospital during your injury/illness? If so, how come? What impact did this have on you?

3. Discharge Experience
   a) When and how did you first come to realize that you would soon be discharged from the hospital?
   b) Do you think your discharge happened at the right time?
   c) What kind of plans were made to help you manage at home after your discharge?
   d) Who made these plans?
e) Were you involved in deciding what kinds of support you would need at home? What were your needs?
f) Were your family or other people from your community involved in discharge arrangements for you? If so, how?
g) Did you and your family receive the type of information needed to care for you at home? If not, what other information would have been helpful?
h) Did anyone follow-up with you at home to see how you were managing? If so, who?
i) If you were transferred from a larger hospital to your community hospital, how did that fit in with your discharge plan?
j) Overall, would you say that the hospital adequately prepared you for discharge? Why or why not?
k) If you could change anything, what would you change in the discharge process you went through?
l) What worked well for you and should be used with other patients?
m) Are there any other comments that you would like to make about the discharge process utilized at ____________ hospital?
Physicians’ De-Contextualized Themes and Re-Contextualized Categories

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<tr>
<th>Category</th>
<th>Themes</th>
<th>Sample Statements from Transcripts</th>
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| I. Physicians’ perception of discharge planning at the local hospital   | 1. Informality/flexibility         | “I think that there is also a greater informality with regards to decision making”  
“we just sit around table and chat about it, to decide what we think is the best way to approach it”  
“we are a little lax here. Discharge planning isn’t so urgent”                                                                                      |
| II. Perceived strengths of the hospital/community at facilitating discharge planning | 2. Personal relationships          | “in a small town you just know the issues, you know the people, you know the patients, you know the workers”  
“the kind of, you know, closer relationships, between patients and the nursing”  
“We do everything, from chronic to acute to people’s banking, to their marital problems, job problems, financial problems and these just come to you.” |
|                                                                          | 3. The hospital as a resource      | “We often have people come back for dressings to the emergency room or medications. Sometimes I arrange a follow-up as an outpatient in the emergency the next morning.”                  |
|                                                                          | 4. Provincial home care nursing/home support services | “home care nursing definitely needs to be expanded because it isn’t 7 days a week”  
“The home [support] care that they get is great”                                                                                                   |
|                                                                          | 5. Public health nursing           | “public health is good for maternity follow-ups”                                                                                                                   |
|                                                                          | 6. Community counselling services  | “we had very good and motivated alcohol and drug counsellors who did a good job”                                                                                      |
| 7. Other formal services | "We have a massage therapist who does a lot of physio type work and she if really a lot of help"
| 8. Informal supports | "well it’s a tight community so their neighbours will keep an eye on them and their families will keep an eye on them.”
| 9. Patient value of independence | "We’re pretty stoic here.”
| 10. Physician follow-up | "they don’t want to be here”
| 11. Lack of specialized staff at the hospital | "I need to bring them back to the clinic, you want to be on the nice side”
| 12. Limited informal supports | "sometimes I arrange a follow-up as an outpatient in the emergency the next morning or in my office as soon as possible and I just make sure that they get a contact”
| 13. Lack of home care nursing/home Support | "I think our girls do all right but they are not experts at these things”
| 14. Lack of community rehabilitation services | "In some families, for whatever reason, they just don’t care. Simple as that.”
| 11. Lack of specialized staff at the hospital | "they don’t have enough [home care nursing]. Like i want to discharge somebody but if I discharge them too close to the weekend, well forget that.”
| 12. Limited informal supports | [home support] “isn’t always available in the amounts people require. Overnight care is a problem.”
| 13. Lack of home care nursing/home Support | " You have people with big health problems that need physio and OT and they are major depressed because they can’t work and it’s taking them longer to recover”

III. Characteristics of the hospital/community perceived to negatively impact discharge planning
| 15. Lack of mental health services | - "there are a lot of other mental health needs, supports that in bigger centres are available for patients which we don’t have"
| 16. Lack of community social services | - "all of us have basically stopped working together with social services except in the cases of family violence or child abuse because they are very limited in how far they can help us"
| 17. Distance factors | - "if they live out across the lake, there is no way" [to get services]
| 18. Lack of LTC/ALC beds | - "having some kind of long term care or intermediate care set up where patients could be taken away from the hospital so the hospital could be just acute care"
| 19. Community norms | - "there is a lot of social issues inside their boundaries [reserves]"
|                      | - "Substance abuse is a huge issue [on reserve]"
### Nurses’ De-Contextualized Themes and Re-Contextualized Categories

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<th>Sample Statements from Transcripts</th>
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| I. Approach to discharge planning              | 1. Informality/flexibility       | - "not on a formal say, rounds or a formal team conference we just do it informally”  
- "we need to be very flexible and we are flexible” |
|                                               | 2. Personal relationships        | - “when it is a small town like this you know everyone and you know the connections like you will know that so and so has a sister or a cousin or their friends with whoever”  
- "we know who has friends or relatives, we know where they live and what not and we will take that into consideration” |
|                                               | 3. Hospital as a resource        | - "we tell them that they can come up here anytime or phone us, I often tell particularly maternity patients, call us, we’re here 24 hours a day”  
- “we generally supply that from the hospital until such time that they get their own” |
<p>|                                               | 4. Home care nursing/home support services | - &quot;if home care can’t pick them up, they don’t get discharged” |
|                                               | 5. Public health nursing         | - “people feel very free to call the public health nurse with any questions” |
|                                               | 6. Community counselling services | - &quot;come right to the hospital where they do their first initial intake and then that visit determines what it is that they need” |</p>
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<td>[Nursing results continued]</td>
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| 7. Other formal support services | -“the Red Cross is where they get equipment”  
-“RCMP victim services is very helpful in trauma cases like MVAs” | |
| 8. Informal supports | -“A lot of people have good friends. Friends play a big part in this community. Not all of the elderly have family but they do have good friends and it shows itself many times here”  
-“we know the patient’s neighbour that sort of thing. It is very close knit and we can call and say look, so and so is going home, ... can you drop in or look in on him over the weekend” | |
| 9. Generalist nursing role | -“we [nurses] learn to do physio”  
-“There’s me ... I know all aspects” | |
| III. Characteristics of the hospital/ community which negatively impact discharge planning | 10. Lack of specialized staff in the hospital | -“I don’t know how to do speech therapy”  
-“I just hope I’m doing it right” |
| | 11. Limited informal supports | -“you can’t send them home because there is no support, sometimes people are sent home and you just know that they are going to be back next week, because they are just not going to get the care that they need”  
-“there was a lady who had a wood stove, no body to help, the house was getting cold, so she stayed” |
<p>| | 12. Lack of home nursing/home support services | -“Monday to Thursday, for four hours a day and hopefully by the end of that time, they have taught someone else to do it or made arrangements for them to come up to the hospital and get it done” |
| | 13. Lack of public health nursing | -“they [maternity patients] were being missed in the community” |</p>
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<tr>
<th>Nursing results continued</th>
<th>14. Lack of community rehabilitation services</th>
<th>“if you have a back problem you have to drive two hours, and then two hours back. It’s too much”</th>
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<td>15. Lack of mental health services</td>
<td>“I think with the mentally ill it [services] is lacking here”</td>
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<td>16. Lack of community social services</td>
<td>“they [financial workers] won’t come up here. The have to go to the office”</td>
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<td>17. Distance</td>
<td>“some of them would be regarding distance, because we can only supply service within a certain radius and in a rural area not a lot live in the town.”</td>
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<td>18. Lack of LTC/ALC beds</td>
<td>“unless there is something that is kind of half way between the hospital and an extended care facility, they can’t really make it home so there they are stuck in acute care”</td>
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<td>19. Community norms</td>
<td>“it’s tough on the reserves. Lots of drinking, lots of violence”</td>
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<td>“there are a lot of old homes with stairs and the bathroom upstairs and not laid out especially for the elderly or for someone else who is mobility compromised”</td>
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<td>20. Nursing attitudes and time constraints</td>
<td>“our attitudes, sometimes we feel personally that the person isn’t ready to go so we’ll let them stay a while, it is the wants of the nurses or the patient that is holding them back”</td>
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### Former Patients' De-Contextualized Themes and Re-Contextualized Categories

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| I. Personal/Family influences on the discharge plan | 1. Personal relationships | -“Oh yes, they all know me up there [at the hospital]”  
-“[a nurse] drove me to Prince to visit my mother” |
| | 2. Informal supports | -“there’s my landlord and if I didn’t reach him when I needed someone and just sloughed it off, he’d break my neck”  
-“if I didn’t have children, I don’t know what I would have done” |
| | 3. Valuing independence | -“I’m old, but I’m tough”  
-“I like being on my own” |
| II. Progression toward discharge and the discharge plan | 4. Hospital as a resource | -“the hospital gave me one [glucometer] until I could get my own” |
| | 5. Home care nursing/home support services | -“she’s [homemaker] coming by everyday and [home care nurse] will be coming by to check on me” |
| | 6. Other formal services | -“and I have a lifeline phone here” |
| | 7. Generalist nursing role | -“they’re not just nurses, they’re there for your mental well-being too”  
-“the nurses helped me walk” |
| | 8. Physician follow-up | -“the hospital didn’t follow-up, but the doctor called me at home”  
-“Dr. [family doctor] takes good care of me” |
| III. Suggestions for improving discharge planning | 9. Lack of specialized staff at the hospital | -“the nurses are great – they try to do everything, but they are not specialized” |
| Former patient results continued | 10. Lack of community rehabilitation | “They couldn’t get me in as an in-patient [at the regional hospital’s rehabilitation unit]. The sooner you start physio, the better it is. Well I sat, I waited there for five weeks. We have nothing here”

11. Distance | “if I didn’t have children I would have had to hire somebody or try and ride the bus or the train because I was too sick to sit up for that length of time. The kids had to make a bed in their vehicle so that I could lay down.”

12. Perceived lack of information provided by health care professionals | “they don’t have home care nurses in this town”

12. Patient costs to travel away from home community for needed services | “they didn’t say anything about what to watch for, or pay attention to this or that, or come back if this happens, they just said ‘go home’”

“Why would they book my appointment [at the regional centre] at 8:30 in the morning? We’ll have to go the day before. Let’s hope the roads are good. Maybe we can get into that Easter Seal place. Hotels add up. It’s a good thing [husband] is pretty easy going”

“I can’t wait to get my life back to some kind of normal” [patient stayed with relatives in another community in order to access rehabilitation services.”]